THE CANADIAN HOSPITAL

OFFICIAL JOURNAL
CANADIAN HOSPITAL COUNCIL

APRIL, 1951

Mount Sinai Hospital CLEVELAND, OHIO

Saves ⅓ of former operating cost

WITH NEW AMERICAN-EQUIPPED LAUNDRY

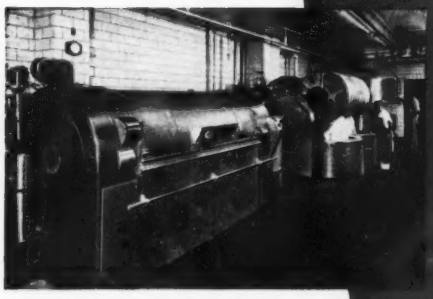
Since installation of their new "AMERICAN" equipped laundry, 410-bed Mount Sinai Hospital, Cleveland, O., has *saved ⅓ of their former operating cost.*

Our Laundry Advisor made an exhaustive study of the Hospital's clean linen needs. He then recommended laundry equipment of proper type and capacity, and submitted a floor plan of the laundry layout to insure maximum operating efficiency. As the result of his recommendations, Mount Sinai Hospital has benefitted in the following ways:

- *Fewer operators needed*
- *Shorter working hours*
- *More efficient work flow*
- *Faster return of linen to service*
- *Smaller linen inventory required*
- *Better quality work*

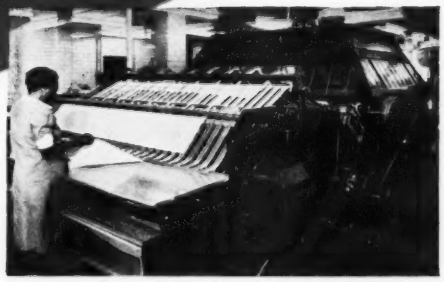
Our Laundry Advisor can help YOU make similar savings. His free services are available to hospitals, large or small, *without any obligation whatever.* WRITE TODAY.

Remember . . . Every Department of Your Hospital Depends on the Laundry.



Time and labor are saved at Mount Sinai Hospital w[here] CASCADE Unloading Washers, and NOTRUX Extractor (sh[ares] washers). Pressing buttons automatically unloads work fr[om] into NOTRUX Containers. Containers then travel by overh[ead] to the Extractor where they are loaded and unloaded by ele[ctric]

Four ZONE-AIR Tumblers (shown above, left) quickly fluff-dry wa[sh] quiring no ironing. NURSES' PRESS UNIT (at right) enables one opera[tor] to completely machine-iron garments in a simple, speedy sequence [that] saves time and motions.

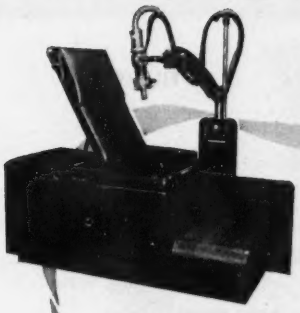


Linens are beautifully ironed, at a high rate of speed, on this 8-Roll STREAMLINE Flatwork Ironer with AIRVENT Canopy. TRUMATIC Folder, at delivery end of Ironer, automatically quarter-folds large linens lengthwise, enabling only one receiving operator to handle entire output of ironer.

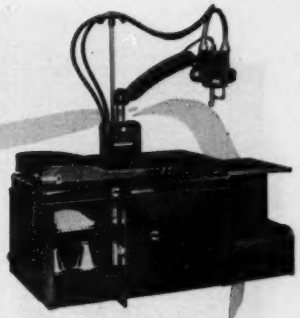
The CANADIAN LAUNDRY MACHINERY CO., LIMITED

47-93 STERLING ROAD, TORONTO 3, ONT.

WESTERN REPRESENTATIVES—Stanley Brock Limited, Winnipeg, Calgary, Vancouver.



Zephyr "60"
Grenz-ray, "contact," and conventional technics. 10 KVP to 60 KVP up to 50 MA.



Zephyr "120 Airflow"
For average schedules of superficial therapy up to 120 KVP. 120 KVP at 3 MA continuous; 120 KVP at 5 MA intermittent.

There is a Picker "Zephyr" for *any* technic you may wish to use in the field of superficial or intermediate x-ray therapy.

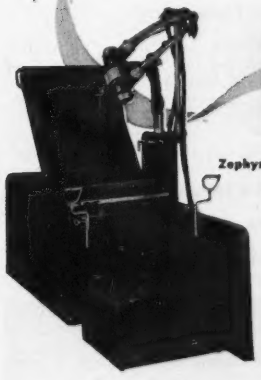
There is a Picker "Zephyr" for every therapy work load . . . occasional, intermittent, or continuous.

In short, the "Zephyr" line exemplifies the Picker policy of supplying the *right* machine for the right job every time.

"Zephyr"

x-ray therapy equipment

Picker x-ray



Zephyr "120 Oilflow"
For heavy-duty work loads of superficial therapy up to 120 KVP 120 KVP at 10 MA continuous.

Zephyr "140"
Superficial through intermediate therapy up to 140 KVP Rating 140 KVP at 8 MA continuous.

PICKER X-RAY OF CANADA, LIMITED
1074 Laurier Ave. West
Montreal

Contents

Volume 28 **APRIL, 1951** No. 4

(For Subscription Rates See Page 98)

when Carbohydrates
are indicated—

prescribe **10% *Travert*®**

in the same way you are accustomed to using 5% Dextrose

Provide your patients with twice the calories of 5% Dextrose with no increase in fluid volume or vein damage. Since ***Travert,***® (*Invert Sugar, Baxter*) is so rapidly utilized, it is now possible and practical to approach complete carbohydrate alimentation—intravenously.

10% *Travert*® solutions are available in water or in saline. They are sterile, crystal clear, nonpyrogenic. 150 cc., 500 cc., 1000 cc. sizes.

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The Federation of Hospital Associations in Canada in co-operation with the Federal and Provincial Governments and the Canadian Medical Association, and the Blue Cross Plans.

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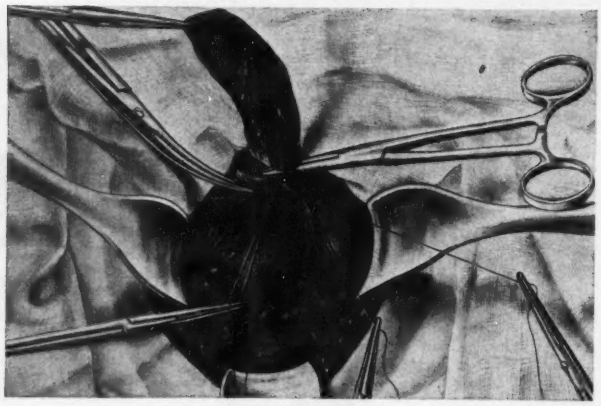
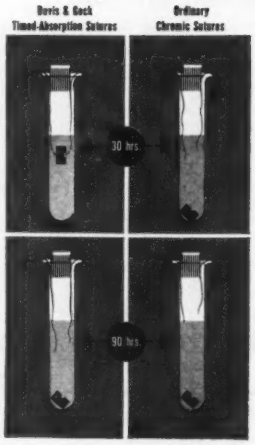
During the critical first 4 days depend on



"TIMED-ABSORPTION" CATGUT

Because "timed-absorption" catgut (surgical gut) has a *measurable* and *predictable* rate of digestion, demonstrated by extensive tests, it remains intact until the wound has gathered support of its own. Because "timed-absorption" catgut does not digest prematurely, it assures strength when needed most—during the critical first 4 days following major surgery.

Processed by an exclusive Davis & Geck method embodying accurately graded degrees of tanning, "timed-absorption" catgut has an absorption curve that parallels the changing tissue conditions of healing. Resistance to digestion is maximal during *early* repair. Later, when artificial strength is no longer required, dissolution is rapid and complete and no remnants of gut remain.



Comparison of D & G "timed-absorption" medium chromic catgut, size 0, with ordinary medium chromic size 0 catgut. Both types of catgut are suspended in a trypsin solution and weighted. Note that at the end of 30 hours D & G "timed-absorption" catgut remains intact; the weight is still held suspended up to 90 hours. Contrast with an ordinary chromic catgut suture which has begun to digest and breaks under the slight tension created by the weight at 30 hours. In human tissue all chromic sutures are digested *more slowly*, but the ratio between the two types remains the same.

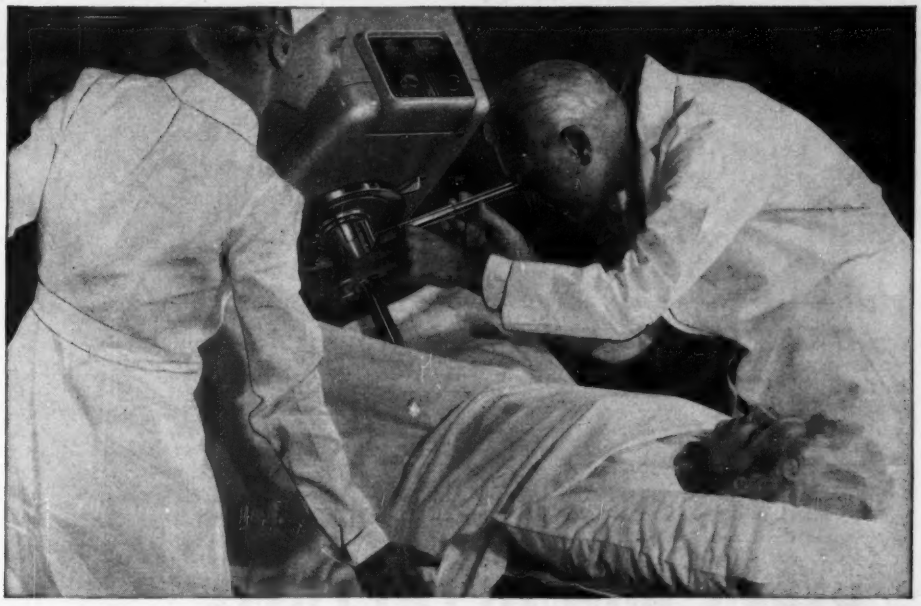
D & G catgut sutures have a special matte finish. They tie readily and do not slip at the knot. Pliability is exceptional and tensile strength, diameter for diameter, is guaranteed unexcelled by any other brand. No wonder so many surgeons agree on D & G.

There is a D & G suture for every surgical purpose. Available through responsible dealers everywhere.

DAVIS & GECK, INC.

57 WILLOUGHBY ST., BROOKLYN 1, N. Y.

4 reasons why the Maximar 250-III is adaptable to the most exacting technics

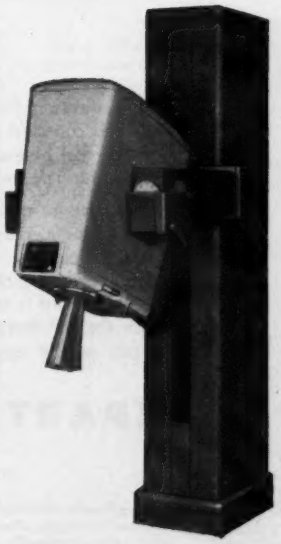


1 **Small symmetrical tube head** facilitates positioning to treatment area. Provides convenient access to difficult treatment areas with unobstructed view of the area while positioning for treatment. New coning system eliminates the conventional master cone, to permit attachment of treatment cones direct to the tube head.

2 **Finger-tip control.** Vertical and angular adjustments of the tube head are obtained through motor-operated mechanisms controlled by finger-tip switch on the face of the tube head. Angle indicating scales on the supporting arm facilitate the recording of any tube head position, in view of duplicating.

3 **Serves also for superficial and intermediate therapy.** Complete range from 80 kvp to 250 kvp makes this equipment serve for superficial and intermediate, as well as for deep therapy. The small, symmetrical tube head facilitates the directing of radiation to all parts of the body — accurately to the smallest prescribed treatment area.

4 **Unusual compactness.** Special consideration was given to conservation of floor space in the design of the Maximar 250-III. A glance at the illustration to the right tells the story. In fact, the Maximar 250-III occupies only 3¼ square feet of actual floor space! See your GE representative or write the office nearest you — General Electric X-Ray Corporation, Limited, Montreal, Toronto, Vancouver, Winnepeg.



GENERAL ELECTRIC
X-RAY CORPORATION
LIMITED
MONTREAL TORONTO VANCOUVER WINNIPEG

HERE'S HOW TO CUT COSTS...

Yet please everybody!

IT can be done . . . even in the food department, because you can add variety to the meals, yet cut the cost of them without reducing their nourishing value.

Here's how! Serve more fish dishes. There are more than 60 kinds of Canadian fish and shellfish available in either fresh, frozen, smoked, dried, pickled or canned form. Every kind is tempting and tasty, with the full flavour and tang of the sea or the appetizing delight of the fresh water fish.

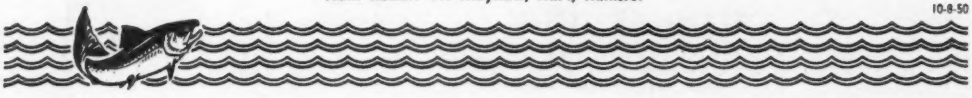
And fish combines with other foods, such as salads or vegetables, to make economical meals that have a piquant, different flavour . . . that turn that "regular diet" into a tasty surprise every time such meals are served. Try serving fish more often. Use it in many different ways . . . they're all good. You will cut your food costs and keep everybody happy when you serve more fish.

DEPARTMENT OF FISHERIES

OTTAWA, CANADA

Hon. Robert W. Mayhew, M.P., *Minister*

10-8-50



100% Frigidaire Refrigeration user for more than 20 years...

Ridley College chose Frigidaire for new Upper School kitchen

● Could there be stronger proof of the satisfaction Frigidaire refrigeration equipment gives? Yet Frigidaire records show many hundreds of cases such as that of Ridley College, where fifteen-year, twenty-year and twenty-five-year users have come back to Frigidaire for more equipment or replacement equipment.

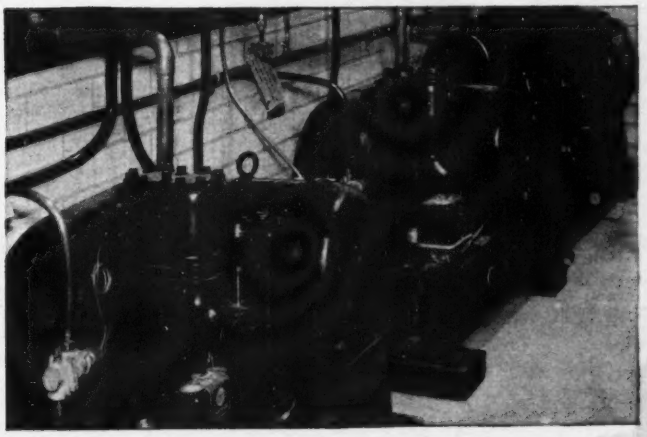
Learn How a *Free Analysis* of Your Cooling Requirements May Mean Better Refrigeration At Less Cost

The type of refrigeration equipment used, and the kind of performance it gives, can make an important difference in the operation of any institution, business or industry. Frigidaire has developed a valuable service called the FRIGIDAIRE REFRIGERATION SECURITY ANALYSIS which quickly and simply demonstrates the truth of this.

Consult your Frigidaire Commercial Refrigeration Dealer about it. He'll give you a clear-cut report based on a special analysis of your business or institution and Frigidaire's 30 years of experience with all kinds of refrigeration equipment.

From this analysis, you'll learn what type of equipment would be best — what replacements or additions, if any, are needed — how long it will take new Frigidaire equipment to pay for itself.

This valuable service is free. Call in your local Frigidaire Commercial Refrigeration Dealer today. Or mail the coupon.



A. A. Widdicombe & Son, St. Catharines, Ontario, who sold the original Frigidaire equipment to Ridley College 20 years ago, also made this latest installation.

Frigidaire Products of Canada, Limited
Dept. H
Leaside, Ontario

I would like to take advantage of your free Frigidaire Refrigeration Security Analysis:

Name.....

Address.....

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FRIGIDAIRE Products of Canada, Limited, Leaside, Ontario
FRIGIDAIRE IS MADE ONLY BY GENERAL MOTORS

Across the Desk

By C.A.E.

New Use for a "Waste" Material

To the many hospitals now using the Expendable Infusion Sets of Baxter Laboratories, the St. Francis Hospital in Litchfield, Illinois, offers an interesting suggestion.

Ordinarily, after parenteral infusions, hospitals throw away the expendable plastic tubing, as recommended by Baxter Laboratories. At the St. Francis, however, they have found a new use for the tubing. They now clean and dry the coloured tubing and then give it to hospital patients who make many interesting articles in occupational therapy. Patients weave or braid the tubing into belts, shade and lamp pulls, glass holders, place mats, baskets, purses, and other interesting novelties. All these articles are quite attractive in original colours of the tubing, but several hospitals now dye the tubing in many different colours for even greater appeal.

* * * *

A. S. Wood.

Abbott Promotions

Mr. A. S. Wood, who has been doing promotion work in Montreal Hospitals for the last few years, is moving to Ottawa where he will supervise sales activities for the Eastern Ontario district. Mr. Art Caplan, well known among the retail Drug trade in Montreal, will now be active in a sales-counselling capacity. New duties will also include local hospital promotion.

* * * *

The Body in Slow-Motion X-Ray

Among the advanced types of x-ray apparatus is cine-radiography. With the aid of this apparatus, x-ray cinematograph films, in slow motion or at normal speed, can be made of all parts of the body. The films thus made will prove invaluable to the doctor because he will be able to follow the movement of joints, watch the action of the heart or the processes of digestion, and repeat them over and over again.

The idea of cine-radiography is not new, but only now has it been possible, by using new developments in both x-ray and optical technology, to produce moving x-ray pictures of a sufficiently high standard of quality to satisfy the exacting demands and, at the same time, to eliminate all risk of injury to the patient.

(Continued on page 16)

The Keleket Overhead Tubestand

The well known quality of Keleket equipment was never more obvious than in this versatile Overhead Tubestand unit. It incorporates many new ideas expressed by some of the most widely known X-ray authorities on this continent.

OUTSTANDING FEATURES

- Unobstructed floor space.
- Maximum table coverage.
- Longitudinal travel dependent only on room dimensions.
- 72" transverse travel.
- 45" vertical travel, from 35" to 80" above the floor.
- Stereoscopic shift on both longitudinal and transverse movements.
- Electric locks on longitudinal, transverse and horizontal movements.
- Designed to accommodate and fully counterbalance any of the high energy radiographic tubes and therapy tubes.

Particulars on this new Keleket development may be obtained from your nearest X-ray and Radium office.

X-ray AND Radium INDUSTRIES LIMITED

261 Davenport Rd., Toronto 5

Moncton — Quebec — Montreal — Winnipeg — Regina — Calgary — Edmonton — Vancouver

48 hour

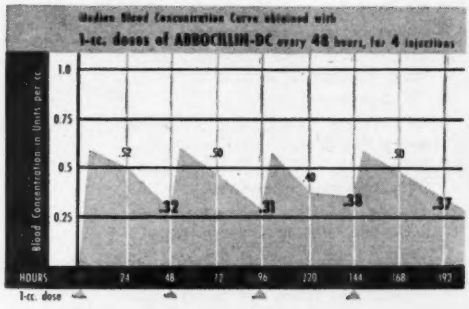
Penicillin Repository

OBTAINED WITH A SINGLE 1-cc. DOSE

● A single 1-cc. dose of ABBOCILLIN-DC consistently affords 48 hours of moderately high penicillin concentration in the blood. You—and your patient, too—will appreciate this *truly repository* pencillin therapy, for it means that only 1 cc. every 48 hours is adequate for the treatment of ordinary pencillin-susceptible infections. In infections which call for high concentrations for protracted periods, a cumulative effect can be obtained by injecting 1 cc. every 24 hours or less. You'll find ABBOCILLIN-DC effective wherever repository penicillin is indicated. Can be kept at ordinary room temperature, ready for instant use. Contains no oils or waxes, flows freely through the needle. Available in single units or in boxes of 12 units.

Abbott

ABBOTT LABORATORIES LIMITED, MONTREAL



ABBOCILLIN®-DC

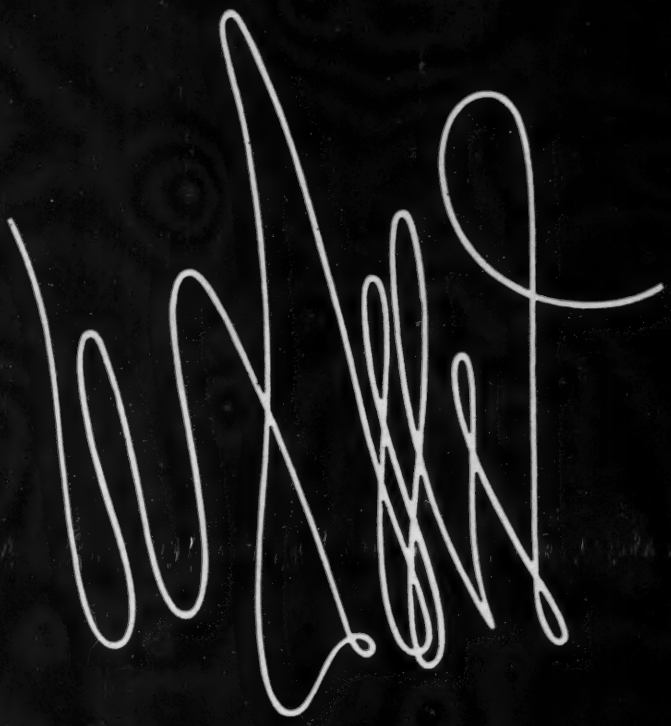
Penicillin G Procaine in Aqueous Suspension

600,000 units • Double Concentration

In B-D* 1-cc. Disposable Cartridge Syringe

*T. M. Reg. Becton, Dickinson & Co.

always an unmistakable pattern . . .



RAY-TEC

x-ray-detectable

SPONGES

The X-ray-detectable monofilament in RAY-TEC Sponges always appears on the X-ray plate in an unmistakable 'string pattern' regardless of the angle from which the picture is taken. The radiologist knows what to look for, what to find, and it is easier because the RAY-TEC monofilament covers a wide area on the X-ray plate. The soft, non-abrasive monofilament is distinctive and cannot be confused with bone structure or artifacts.

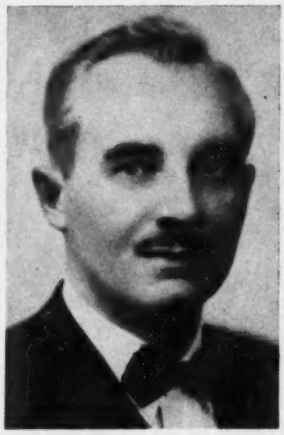
Write for samples to Hospital Division

Johnson & Johnson

Across the Desk

(Continued from page 12)

New President of Air Reduction



Announcement has been made of the appointment of Mr. Hugh D. Cameron to the position of President of Air Reduction Canada Limited. Mr. Cameron will also continue to serve in his capacity of President of Ohio Chemical Canada Limited.

Mr. Hugh Chambers, who has been President of Air Reduction Canada Limited for many years, has been elected Chairman of the Board.

* * * *

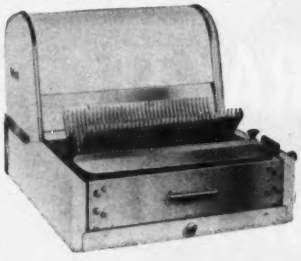
Changes in Staff of Ingram & Bell

Ingram & Bell Limited announces a number of changes in sales representation in the Province of Quebec. Mr. Emile Beauchamp, for four years representing the Company in Quebec City and the surrounding territory, has succeeded the late Mr. Paul Lavallee. Mr. Peter Rohac, who for two years has serviced the Quebec North West territory, succeeds Mr. Beauchamp. Mr. Roger Giard, associated with their Montreal Branch for the past four years, now takes over Mr. Rohac's former territory.

* * * *

New Berkel Bread Slicer

Of interest to dietitians and other kitchen personnel is a new Berkel Bread Slicer, as illustrated. The new Model MB Berkel slices bread in one operation in standard slices of 7/16" thick. Each and every slice is neat, uniform and appetizing. It is easy to operate, entirely safe, and can be easily cleaned.



An attractive illustrated folder is available by writing to Berkel Products Co. Limited, 2199 Bloor St. West, Toronto 9.

(Concluded on page 22)

INTRODUCING THE NEW Hotpoint HRG7

SUPERange

DOES THE WORK OF TWO RANGES!

... grilling and boiling off the same top.

SIMPLY:
turn the dials to get
... all hotplate top
... or all griddle top
... or part hotplate—part griddle

1. Each 12" x 24" top cooking plate is independently controlled by Hotpoint's exclusive new thermostat development — the ROBOTROL — gives accurate control, whether for grilling or boiling, from 250° to 850°.
2. Automatic oven with new air-cushion deck.
3. Tough, super-strong, super-efficient Calrod heating elements.
4. Convenient, time-saving signal lights for accurate cooking.
5. Colorful styling to give your kitchen a "showplace" beauty and increased efficiency . . . matches other Glamour Line cooking units.
6. Brand-new Permalucent Silver Grey finish defies fingermarks and grease smears . . . withstands heat and fumes . . . cleans easily.

THE SUPERANGE IS ONLY ONE UNIT IN HOTPOINT'S NEW

Glamour Line

which includes

- **RANGES**
- **BROILERS**
- **FRY KETTLES**
- **GRIDDLES**
- **ROAST OVENS**
- **BAKE OVENS**

Distributed in Canada by

CANADIAN GENERAL ELECTRIC COMPANY
LIMITED

HEAD OFFICE: TORONTO — Sales Offices from Coast to Coast

51-M-1

THE IMPROVED

FLEXOPLAST

ELASTIC ADHESIVE BANDAGE
with the NON FRAY EDGE

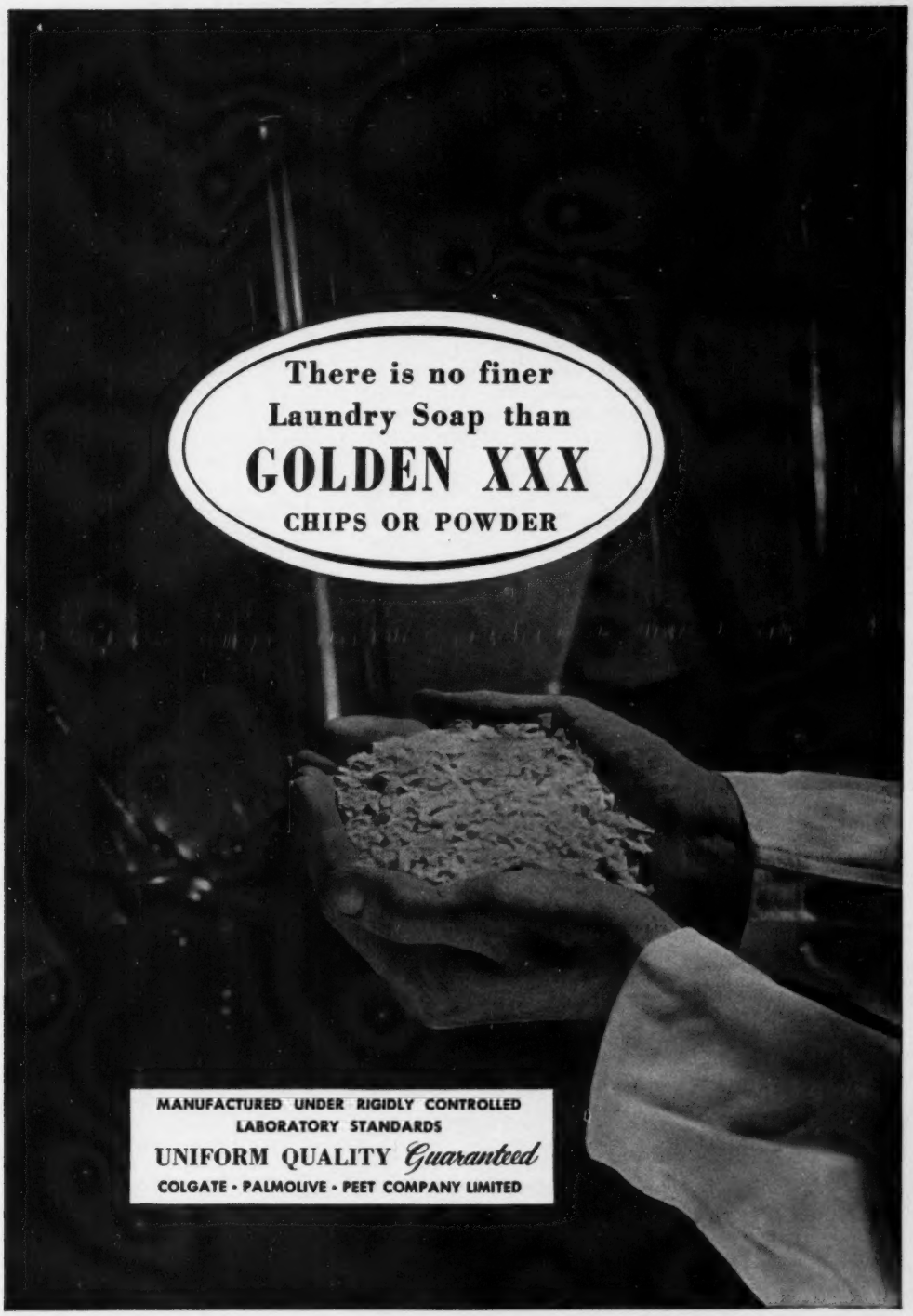
Each strip of Bandage Fabric is woven separately with individual control of thread tensions.

The improved Non Fray Edge provides the Advantage of a Bandage which will lie flat on the Limb.

By reason of the Greater Softness of Doubled Thread, the Flexoplast Fabric is more impermeable to the Adhesive spread, is cleaner on the back and softer and more flexible in use.

THE Stevens COMPANIES

TORONTO WINNIPEG CALGARY VANCOUVER

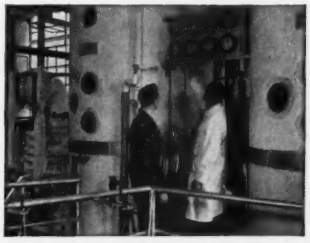

There is no finer
Laundry Soap than
GOLDEN XXX
CHIPS OR POWDER
MANUFACTURED UNDER RIGIDLY CONTROLLED
LABORATORY STANDARDS
UNIFORM QUALITY Guaranteed
COLGATE • PALMOLIVE • PEET COMPANY LIMITED

Modern Equipment + Skilled Workers + Constant Quality Control = GOLDEN XXX PURE SOAP

To bring you the finest possible washing products, Golden XXX pure soap is carefully checked at every step during its manufacture . . .

First, all raw materials coming into the Colgate plant are tested for quality . . . oils are re-refined to meet Colgate standards . . . all other ingredients must measure up to Colgate's rigid, self-imposed standards, before they can be used in the manufacture of Golden XXX.

Second, the mixing and blending of each item used is carefully supervised to conform with a formula that has remained unchanged for many years. And when manufacturing begins, Colgate's Control Laboratory keeps a constant check of every process, every phase of manufacture.



This constant supervision of manufacture, this constant "Quality Control" is the main reason why Golden XXX has always been sold on a "money-back" guarantee basis. Colgates believe Golden XXX is the finest soap you can use . . . and back it up with an absolute guarantee of Quality.

FACTS YOU SHOULD KNOW ABOUT GOLDEN XXX

Because of its medium titre, Golden XXX can be used successfully at moderate water temperatures . . . saving hot water and fuel.

Because of its high detergency and easy rinsability, Golden XXX assures you of perfect cleansing, complete speedy rinsing at hand temperatures, more satisfactory work and fewer rejects.

Golden XXX can be supplied in either chip or powdered form, in either 50 or 100 pound cloth bags. See your Colgate representative or order direct from

COLGATE-PALMOLIVE-PEET COMPANY LIMITED

64 Colgate Avenue, Toronto 8, Ontario

MONCTON, QUEBEC, MONTREAL, OTTAWA, WINNIPEG, REGINA, CALGARY, VANCOUVER

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(Concluded from page 16)

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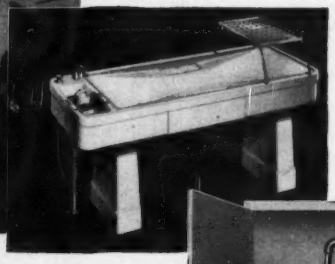

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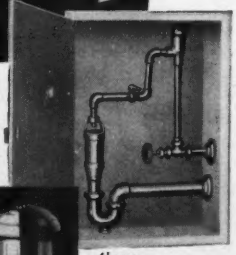

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L. O. Bradley, M.D., Editor

CANADIAN HOSPITAL

Toronto, April, 1951 Vol. 28 No. 4

Obiter Dicta

O.M.A. Prepares Basic By-Laws for Hospital Medical Staff

JUST recently, the Ontario Medical Association completed and approved model "By-Laws for the Medical Staff", one set for intermediate hospitals and a second for smaller hospitals. (See page 30). These rules and regulations are the result of intensive work by a special committee who consulted with many hospital authorities as well as Department of Health officials. The by-laws have been approved by the provincial Minister of Health as a guide for the hospitals of Ontario.

There was a real need for this action on the part of the medical profession who are to be commended for recognizing it and for doing something about it. Too frequently on visiting hospitals, one finds the medical by-laws (usually outlined in the same booklet as the hospital by-laws) celebrating their silver anniversary in the bottom of the bottom drawer or buried on a dusty bookshelf. They are "more honoured in the breach than the observance".

For many reasons—scientific discoveries, specialization, social attitudes and developments—there have been notable changes in the practice of medicine. The tremendous fund of medical knowledge that is available is beyond the ken of the individual doctor. It has become necessary to utilize group approach in order that the patient may benefit by advances in medicine. Unfortunately, rules and regulations to guide and control these new forces and skills have not, in many instances, been followed nor kept up-to-date.

It is pointed out in the article on page 30 that the use of the medical audit has not been fully realized but that it is "one of the best ways of assuring that good medical practices are being carried out in hospitals". Providing a good set of medical staff by-laws is, of course, the important first step. The next logical move is to initiate and conduct regular medical audits within this framework. It can be done if the medical staff wants it. Without the whole-hearted and honest participation of the medical staff, the hospital board (which holds the ultimate responsibility for the quality of medical care) and the administrator can effect a medical audit only with great difficulty. It is vital that there be an active partnership in order to make it an accomplished fact. Modern up-to-date by-laws are an important factor in providing good hospital care. The example of the O.M.A. might well be of great encouragement and assistance to other provinces.

There are further aspects of hospital operation that might also command the interest and attention of our doctors. One facet of current concern which should come under their purview is hospital costs. Administrators are doing their utmost to explain increasing costs to the community. The doctor on whose order the patient is admitted is in a favourable position to tell the hospital story. Yet the practice is not widespread.

Our medical staffs will have to devote some time to learning or re-learning something about the hospital. They are so near and yet so far. We in hospital administration have a stake in giving every assistance possible. Our freedom of action, as well as that of the medical profession, depends on how well the job is done.

The O.M.A. has put a runner on first base, with a solid hit, well-placed. However, the game is only well begun and it remains to be seen what can be accomplished in the remaining innings.

Health Agencies— A Service to the Community

OUR January issue and again the March issue carried short articles about voluntary health agencies; first the Health League of Canada, then the Canadian Red Cross Society, and in this issue, the Canadian Mental Health Association (see page 42). These short stories are the first of a series of articles on the many organizations, voluntary, and governmental, which are active in the interest of a healthy community.

Health services are increasing in numbers and in complexity as needs are realized or demonstrated and as leadership and resources rise to meet the needs. All these organizations, governmental and voluntary, are supplementary and complementary to the community hospital. They can be a real help to the administration and may provide valuable assistance to the patient before and after hospital care. So in the interest of better service each administrator will want to review the functions and activities of other health organizations. Each of these services needs personnel and each contributes to the cost of health services for the community. A clearer knowledge can avoid duplications and ensure better use of present facilities. It can result in co-ordination and co-operation that will be profitable for all concerned.

Ontario Government to Aid Construction of Nursing Schools

THE shortage of training school facilities has been one of the most serious bottlenecks in the preparation of adequate numbers of graduate nurses. Residence and teaching accommodation at hospital and university schools of nursing has been bursting at the seams with classes which have grown steadily since 1939. In spite of overcrowding it has not been possible to prepare nearly enough girls to meet the ever-increasing demand for nursing services.

The announcement by the Minister of Health of Ontario that his government would make available $1,000 per bed toward construction of nurses residences for hospital schools of nursing will be heartening not only in Ontario but across Canada. If additional assistance can next be made available from the Federal Health Grants, we can foresee some early progress toward meeting our nursing shortage.

This development is very pleasing to *The Canadian Hospital*, as the need for financial assistance to hospitals and schools of nursing has been stressed many times in these columns. Such assistance has been urged repeatedly by the Canadian Hospital Council and by the provincial hospital associations.

The action of the Ontario legislature is a very important first step which may be likened to a pebble-dropped in a pond of still water. A series of ever-widening concentric ripples will spread to stir the whole pond into activity. It means that standards of construction must be carefully studied so that the best possible facilities are provided. It means that better methods of selection for the larger classes must be considered.

The parallel need for many more instructors brings us to another major bottleneck. An accelerated and enlarged program of advanced education at our university schools will be necessary and they need facilities and staff very badly too.

The probability of having more school facilities suggests that the experiences of the demonstration school at Windsor and the new program at the Toronto Western Hospital be examined as soon as possible since the time may be ripe for curriculum changes.

Hospital people are sincerely hoping that this type of grants program will become general across Canada. At the same time, each board and administrator will begin to wonder how to meet the bigger budget for nurse education and how soon they may expect financial assistance in operating larger and more numerous schools of nursing.

Do Visitors Prolong the Length of Hospital Stay?

ANOTHER factor in speeding patient recovery and shortening length of stay was pointed up in several recent discussions regarding the ban on hospital visiting during the last flu epidemic. A number of experienced administrators volunteered the opinion that patients got well more quickly and went home sooner when visitors were not allowed. If this could be supported statistically, it would be of great importance since hospital utilization is steadily mounting.

An explanation might be drawn from the old saying—"absence makes the heart grow fonder"—thus patients, yearning for home, hasten their physical and mental mending in order to rejoin the family circle.

Administrators, however, are more likely to attribute it to the absence of certain types of visitors or to droves who overwhelm the patient in conversation and presence, often leaving behind fatigue, frustration, and sometimes fear. Without visitors, perhaps the nursing services have fewer interruptions or it may be that the patient simply gets more complete rest—an important factor.

In any case it would be valuable to learn of hospital experience for the months of January, February, and March, that is, if visitors were banned during the middle month. Determine the length of stay and send the results along for compilation. (Formula: Divide the total number of patients discharged (including deaths) for each month into the total number of patient days of care received altogether by such patients). We may just be overlooking a means of reducing hospital costs.

P.S.—As we go to press, we have learned that as a result of the favourable experience of "no visiting", the hospitals at Windsor, Ontario, have decided to shorten visiting hours and to allow privileges only to immediate members of the family.

Co-ordinating Hospital and Public Health Services

Morley R. Elliott, M.D., D.P.H.,
Director of Health Services, Department of Health and Public Welfare, Winnipeg, Man.

EVERYONE in the field of hospital administration will be influenced to some extent by the future relationships between hospitals and public health services. Therefore, the time would seem opportune to consider mutual interests and concerns.

Too many persons, including many doctors and even some M.O.H.'s, still believe that Public Health is preventive medicine, and that the chief function of a health department is to prevent something that is undesirable, be it an overflowing cesspool, a malodorous dump, or an epidemic. Again, it is unfortunate that some hospital administrators still look upon a health department as a police agency, enforcing regulations which are apt to be inconveniences to the hospital, or even as an outside agency which may interfere with the internal arrangement of the hospital, or lead to undesirable publicity. To be sure, public health services are, to a limited extent, both preventive and regulatory, but their chief function is much more than any of these. Public health is, and should be, a positive program in which every possible measure for improving the health of the community is of major importance. Its services are a positive asset to the resources of any community. The classic definition of public health, given years ago by Dr. Winslow of Yale University, still stands. He said: "It is the science and the art of preventing disease, prolonging life and promoting physical health, through organized community efforts." Any procedure, therefore, which is instrumental in doing these things, including hospitalization, is in the broad sense a public health service.

Public Health Advances

Public health has advanced a long way in the past 50 years. Epidemics have largely been controlled; tuberculosis takes but one-seventh of its former victims; smallpox and typhoid are almost gone; and in fact the incidence and mortality rates of communicable diseases no longer occupy a place of major interest. Childbirth is twice as safe as formerly and infancy three times safer; and our sanitary environment has improved tremendously. The public health horizon is now lifting to other problems, aimed at raising and sustaining a higher level of good health for the whole community. We are interested in such things as housing, nutrition, mental health, accident prevention, diseases of the ageing population, care of the chronically ill, and the health of industrial workers. Dr. Thomas Parran, former Surgeon General of the U.S. Public Health Service, says: "There is general agreement that we are in a period of transition as regards the role of public health in modern society. Emphasis has been shifted from the traditional concepts of giving alms to the sick, of sanitation and quarantine, to the problems of providing adequate facilities and services to all who need them."

Hospital Progress

Equally dramatic changes in the functions of hospitals have also been in progress during this time. In the past, the popular and almost universal concept was that the hospital was a place to care for the sick, a few being teaching centres as well. But modern knowledge of the factors influencing disease has brought to light the effect of environment—physical, social, and economic—on the development and cause of illness. This knowledge has indicated that illness is not always a matter completely centred in the individual, but frequently has much to do with the circumstances under which he lives and works. Modern medical care is directed towards the patient as a whole, and not just to the part that hurts. The patient who has the disease is treated, as well as the disease that has the patient.

Leading hospital administrators have been keenly aware of this aspect of medical care and have long advocated that hospitals should participate in a larger area of community effort towards the promotion of health. They believe that hospitals owe a responsibility to their communities in regard to activities affecting individuals outside of, as well as in, hospitals. Dr. Malcolm MacEachern says that the functions of a hospital are (a) the care of the sick and injured; (b) the education of physicians, nurses, and other personnel; (c) public health, the prevention of disease and promotion of health; and (d) the advancement of research.

The report of the Commission on Hospital Care in 1947 stated, "The service frontier of the hospital has been extended from the sick person in the hospital bed, to the potentially ill person in his normal living. The hospital can be the medium through which doctors, nurses, and both voluntary and government health agencies can pool their efforts for improving the health of the people. The general hospital can no longer confine its attention to patients within the institution. It must be a public service agency reaching out into the community, contributing and assisting in all matters pertaining to the health of the people. Its responsibilities include all phases of public health."

Curative and Preventive Medicine

"These are strong evidences that the border lines between curative and preventive medicine are fading out, and that any attempt to fix such

An address presented at the Western Canada Institute for Administrators and Trustees, Winnipeg, Oct., 1950.

boundaries is no longer realistic." It was recognized long ago that the prevention of tuberculosis could not be divorced from treatment. The prevention of pneumonia is partly through the treatment of common upper respiratory infection. Is the hospitalization and treatment of a woman with typhoid fever to be called curative medicine for her, or preventive medicine for the community? The point is, obviously, that the two are no longer separable, if indeed they ever were. The time is ripe to stop talking about them as separate entities, but to use instead the term "Medical Care", whether that care is furnished to the chronic invalid, the acutely ill, the mildly indisposed, or the absolutely healthy. This medical care should include all the various types of facilities and services necessary to meet the needs of both sick and healthy, because they are so closely related one to another, and so interdependent both professionally and economically, that they should be considered as an entity. The hospital should be the physical and organizational centre through which this concept of medical care is given to the community. A unified service for the healthy, as well as the sick, is necessary from the point of view of the people to be served, the health professions, the medical care facilities, and the community at large.

It was in consideration of reasons such as these, and many others, that the American Hospital Association and the American Public Health Association issued a joint statement in May 1948 strongly recommending that, where circumstances justify and permit, there should be joint housing of hospitals and health departments and, if possible, the offices of physicians, dentists, et cetera. The trend is unmistakably in that direction. A survey that was undertaken in the United States about a year ago showed 8 health departments actually housed in hospitals, and 23 adjacent to one. One-fourth of all applications received by the U.S.P.H.S. contemplate a combined health department and hospital unit. In Manitoba we are proud that, owing to the vision of men like Graham Davis (who made the original hospital survey in this province in 1941), Dr. Fred Jackson, our former deputy minister, and others on the Hospital Council of Manitoba, we can now be considered among the leaders in this field of co-operation. The headquarters of three of our local health departments are now located in district hospitals and, almost without exception, as new district hospitals are planned and constructed in health unit areas, provision is made in the original scheme and designs for this joint housing. By this means, the local health department attains new stature, dignity, and public appreciation, and the hospital suffers not at all. This is in keeping with the most modern ideals of hospital planning today, and is endorsed by practically all leading medical and hospital authorities. To name only a few examples, we could cite the Council for Medical Care of the American Medical Association, Commission on Hospital Care of New York City, Division of Hospital Facilities of the U.S.P.H.S., American Public Health Association, and the American Hospital Association.

Now, I would like to discuss briefly a few areas in which hospitals and public health services could very well begin to achieve practical results through a closer co-operative working arrangement.

Laboratory Service

Unquestionably, both hospital and health departments have a vital interest in the development and planning of laboratory facilities. It is essential to the proper functioning of a hospital and to the work of the department in communicable disease control. A joint laboratory will provide, at least in rural areas, a well integrated service, impossible otherwise, and give the community a higher calibre of service. In Manitoba, these services are shared in two areas and a report of the Advisory Commission, released in September, indicates plainly that these hospitals have a service superior to any others in the rural parts of the province. Plans are progressing for extension of this service. It has also proved useful in rural counties in Maryland and elsewhere. Even if the hospital operates its own local laboratory, it is not advisable to rely too assuredly on the results of certain examinations not performed frequently enough to keep the nurse or technician in practice. The health department should maintain a system whereby local laboratories may submit to periodic checking and review of procedures.

Physicians' Offices

In the joint statement previously referred to, issued by the A.P.H.A. and the A.H.A., it is particularly recommended that doctors' offices be included in any new hospital building. This will facilitate laboratory and x-ray examinations of the physicians' patients and prevent unnecessary duplication of expensive technical equipment; make it easier for the doctor to consult his colleagues; minimize the time and effort usually expended in shuttling back and forth between office and hospital; and result in greater convenience to both patient and doctor and better continuity of service to the public. We can speak somewhat with the voice of experience in this regard because, in Manitoba, physicians' offices are already located in ten of our rural hospitals and are planned in four of the hospitals now under construction. If the health department is also located here, the health officer would benefit professionally from more intimate association with the physician engaged in clinical practice. The closer co-operation of the medical staffs with public health programs would be of benefit to both and would certainly give added impetus to the work of the public health personnel.

Public Health Nurses and Social Service

Hospital social service extends from the wards out into the homes of the patients and into various health and social agencies of the community. The patient's disease is never isolated from his background or social situation, which includes his home and family, his work, income, and recreation. When a patient is discharged from hospital, he is often in need of further medical care which hospital social service can help to provide. In western Canada, much of the medical-social work is done by the public health nurse. She can perform many functions in addition to helping the patient carry out his post-hospital program. She will be the scout to

find out the conditions in the community that need medical care; the instrument for urging people to seek medical attention; the teacher to give information about prevention and cure; and the avenue through which those unable to pay are connected with proper sources of relief and help. She must have constant and easy access to the wards and must know her hospital. Co-operative arrangements between the hospital and the public health nurse can prevent duplication of service and increase efficiency. The services which she can provide are an essential part of the complete hospital service, and it should not be too difficult to arrange effective referral systems.

Prevention of Communicable Diseases

There is now very little reason, except in large cities, for special hospitals for communicable diseases. They are economically wasteful and seldom provide service which meets the total needs of the patient. A more rational approach is to use general hospital beds for the care of these patients and, if necessary, to obtain the assistance of the health department in developing effective isolation techniques. This might be facilitated if the hospital appointed a health officer to its medical staff as consultant in communicable diseases. The control of tuberculosis, venereal disease, and others, afford numerous opportunities for joint activity of hospitals and health departments. T.B. and V.D. clinics belong properly at hospitals and not elsewhere. Routine chest x-rays, now done in many of our hospitals, ought to be done in all and, if necessary, the health department should give financial and technical aid in this program. Public health personnel must be willing to assume a greater share of the teaching of communicable disease control to hospital staffs.

Chronic Diseases

The social effects of chronic diseases are among the most important health problems of today. Their long drawn-out effects, their increasing importance in our aging population and the high expense involved, put them in a category beyond the scope of the patient, doctor or hospital. They are becoming to an increasing extent community responsibilities. Much of the valuable information on the incidence of these diseases, which should be studied and used in the development of health programs, can be found only in hospital records. There should be more opportunity for exchanging this information and greater concentration of this type of preventive activity by hospital staffs.

Maternal and Child Health

In this field, many avenues of close co-operation are already routine and still others are desirable.

(Concluded on page 80)

Planning local arrangements: Dr. W. Douglas Piercey, Sister M. Idella, Sister Joseph Edmund, and H. Gordon Hughes, all of Ottawa.

A Forecast of the C.H.C. 1951 Biennial Meeting

PREPARATION of the agenda for the eleventh biennial meeting of the Canadian Hospital Council is well under way. As usual, so many topics and important issues have been proposed for discussion that it is difficult to condense the complete program into the three days allotted to the conference.

Considerable time will be devoted to a study of the National Health Program, with The Honourable Paul Martin, Minister of National Health and Welfare, as principal speaker. Discussion will centre on present and future needs in the hospital field to help hospitals to make their full contribution to the better health of the Canadian people.

The development of civil defence services, with the emphasis on the role of hospitals and national voluntary agencies, will be given some prominence.

The hospital standardization program initiated and conducted for many years by the American College of Surgeons will be reviewed, together with present developments in this field. The attitudes and policies of Canadian hospitals must be determined.

Reports of officials and committees will be received by delegates and consideration will be given to future Council policy on many matters, including educational facilities for hospital personnel. Existing and developing plans for distributing the cost of hospital services will be reviewed and financing hospital care is to be thoroughly discussed.

The opportunity for delegates to see our national capitol and elected representatives in action has not been overlooked, nor the chance to present an outstanding speaker at a dinner meeting. A large block of hotel rooms has been booked and additional accommodation for sisters will be made available at the Ottawa General Hospital. Local arrangements are in the hands of an Ottawa committee consisting of Dr. W. Douglas Piercey, Sister M. Idella, Sister Joseph Edmund, and H. Gordon Hughes.

Basic By-Laws for Medical Staff

Formulated by O.M.A.

G. W. J. Fiddes, M.D.,
Assistant Secretary,
Ontario Medical Association,
Toronto, Ontario.

THERE is a great deal of difference between an ostrich and an eagle. When trouble confronts the first, he hides himself from it, vainly hoping that his worries will soon be over. But the eagle rises well above his difficulty, realizing that a good view of his problem is often the whole solution. The problem of Medical Staff By-Laws confronted the Ontario Medical Association and, believing that there was more wisdom and valour in the ways of the eagle, the directors established a committee, under the chairmanship of Glenn I. Sawyer, M.D., of St. Thomas, Ont., empowered to study many phases of the question. It was brought to the attention of the directors that a great number of hospitals in Ontario had prepared or were in the process of preparing by-laws. Many of these appeared to be unsatisfactory because they fell short of establishing the standards of medical practice which should be maintained in our province. Moreover, the association considered it imperative that the medical profession should establish the method by which it should govern itself in the provision of medical services in hospitals.

The committee was chosen with diligence, for doctors not trained in hospital administration are aware of their lack of knowledge in matters of hospital inter-relations. Although we esteem the medical care of patients as the first purpose of a hospital, we acknowledge that each nurse and dietitian, clerk and laundryman, plays an essential role in the hospital community. Administrative counsel was obtained from certain experienced hospital superintendents who acted as advisers. The geographic distribution of hospitals was considered, so representatives were chosen from the north, east, west, and central areas of Ontario. The needs of the smaller hospital were recognized and members were chosen from district or community hospital staffs. The relationship between hospital by-laws and the Department of Health rating was realized and valuable assistance was given by officials of the hospital division of that department.

The committee was empowered to:

1. Study the organization of hospital staffs.
2. Define the duties of the chiefs of staffs.
3. Study the advisability of the use of the medical audit in hospitals throughout Ontario.
4. Bring in recommendations designed to improve the practice of medicine in hospitals.

Parts 1, 2, and 4, of this assignment have been carefully studied and the conclusions of the committee are to be found in the preface and in the by-laws. The matter of a system of medical audits for hospitals in Ontario was also very seriously considered. Officials of the Association travelled to Chicago and St. Louis where they visited the Division of Hospital Standards of the American College of Surgeons and the American Academy of General Practice.

Following this tour the committee invited Dr. Henry B. Farish of Philadelphia, Penn., a disciple of Dr. Malcolm MacEachern in the development of the medical audit, to address members of the profession at the annual meeting of the Ontario Medical Association in Ottawa. On this occasion Dr. Farish explained in detail the operation of such a plan as it would apply to the medium-sized or larger hospital. A study of this presentation and other sources of material convinced the committee that the medical audit is one of the best ways of assuring that good medical practices are being carried out in hospitals. The committee recommends that hospital medical staffs give serious thought to the matter of self-assessment as it applies to each situation. However, the committee felt that a law should be proclaimed before sending for police to enforce it. The professional staff of a hospital must be organized and aware of their obligations before standards can be maintained or elevated. The committee, therefore, refrained from expressing itself more fully on the subject of medical audits at this time, believing that here, as in childhood, it is better to creep before walking.

Basic material was obtained from many sources both near and remote. Copies of hospital by-laws were obtained from more than a dozen hospitals. Although these varied in the extreme, certain essentials were repeated in all of them and each one added something to discussion and decision. In order to comply with the terms of references the committee spent considerable time in studying the organization of hospital staffs. In our "basic by-laws" we have prepared a graphic "chain-of-command" for the hospital medical staff and defined the inter-relation of one group to another. It is hoped that with this type of organization the staff may work as a unit.

The committee was further charged with defining the duties of the chief-of-staff. In the opinion of the committee the answer will vary with the size and extent of the hospital organization. However, for the sake of clarity concerning the most essential duties of the chief-of-staff as defined in the by-laws, these may be literally interpreted as follows:

1. Clinical oversight of all patients. He is "ex-officio" the physician of every patient in the hospital. He may advise any doctor concerning

Copies of "By-Laws for the Medical Staff" may be obtained by writing to the Ontario Medical Association, 135 St. Clair West, Toronto.

Invoking the Spirit of Service

A recent capping ceremony, enhanced by symbolic candle lighting, was a happy occasion for twenty-one student nurses who had completed their preliminary training period at St. Joseph's Hospital, Chatham, Ontario. Later the students were entertained at a reception in the nurses' residence.

his treatment or obligations. He shall arrange for the medical care of all indigent patients.

2. Adviser to the superintendent in matters affecting technique, patients' services, and the like.

3. Standardization. He is responsible for all matters affecting the medical standards of the hospital. He oversees research, the clinical program, and the relation of records, pathology, post-mortems, et cetera, to the standardization of hospitals. He is director of student intern activities.

4. Co-ordination. The inter-relations of departments and services to form the most efficient unit is his responsibility.

As the work of the Committee on Hospital By-Laws progressed it became evident that the study was a serious and complex one. No set of proposals can be accepted as absolutely applicable to every hospital and staff.

We feel that our responsibility consists of setting forth a basic pattern for the use and guidance of those hospitals and medical staffs desiring high standards and good organization of the physicians serving within the hospitals. The committee has been encouraged by the action of the Council of the Ontario Medical Association in freely discussing, amending, and adopting, these basic by-laws at a special session of that body on December 4, 1950. These by-laws have subsequently been forwarded to the Department of Health for Ontario and given approval as the basic By-Laws for Medical Staff Organization. The co-operation of the Ontario Hospital Association, the Catholic Hospital Council, the Health Survey Committee, and the Department of Health for Ontario have contributed in large measure to the completion of this assignment.

However, we do not consider the whole task accomplished. Having brought forth proposals for Medical Staff organization, the Ontario Medical Association is vitally concerned that these proposals be carried forward. The facilities of the Association will, henceforth, be available for counsel and assistance to medical staffs of hospitals in any honest endeavour to improve the standards of medical care in the hospitals of our province. We feel that this course will be beneficial to the patient, to the hospital, and to the physician.

Program Under Way for Western Canada Institute

The sixth annual Western Canada Institute for Hospital Administrators and Trustees will be held this year in the Drill Hall, University of Alberta, Edmonton, from June 18th to the 23rd, inclusive. The faculty selected for this course of study is comprised of authorities in the various phases of hospital administration and the program, now in the course of preparation, will include addresses, discussion periods, and field trips. General Chairman of the Institute Committee is Dr. A. C. McGugan, University Hospital, Edmonton; Chairman of the Registration and Housing Committee, G. Hollingshead, Royal Alexandra Hospital, Edmonton; and Chairman of the Finance Committee, is L. R. Adshead, University Hospital, Edmonton.

Criticism Tabulation and Reform

Sister B. Bezaire, Reg.N.,
Administrator,
St. Paul's Hospital,
Saskatoon, Sask.

THE terms "patient opinion poll", "x-raying the patient's opinion", "talking back", and "records of complaints", indicate some of the many devices worked out in recent years with a view to improving patient care.

Comments regarding service received in hospitals will certainly be made by whatever means the patient may choose. Most administrators have had the painful experience, at some time or other, of receiving furtive telephone calls or incognito letters—to say nothing of the whispering campaigns which eventually reach their ears. Inviting patients to make their griefs known to the administration is a very healthy practice which can be most constructive for those responsible for the quality of patient care.

Probably in most cases where the system of obtaining a census of patient opinion has been inaugurated, it was decided upon in consequence of certain complaints made about the institution. It is recognized that complaints which cannot be identified are practically impossible to remedy because of the great difficulty in tracing their source.

It was under circumstances such as these that the following method was developed in our hospital nearly five years ago. After much enquiry, a form was devised which, while much simpler than that used by most institutions, has served our purpose quite satisfactorily.

Questionnaire Forms

Regular letter-size sheets are used, with a different colour for each department. The purpose of this is to identify easily the department from which the complaint originated. A brief explanatory note welcomes the patient to our institution and tells him the purpose of the questionnaire, while a foot-note informs the patient that he or she need not add a signature unless so desired. Only three questions are asked:

What dates were you in the hospital?

Were you treated courteously by all?

Were you satisfied with the care you received?

The remainder of the page is divided into two parts. On one side is written: "Please list the things you particularly liked about our hospital"; on the other: "Please let us know the improvements which you consider necessary".

The advantage of this informal type of enquiry is that the comments made by the patient are more spontaneous and we feel that, because of this, they are more significant. One or two examples will illustrate what I mean. We attach more importance to the remark, "I appreciate the sympathetic attitude of the personnel", than we possibly could to a brief answer to a definite enquiry relating to this type of service. Again, the answer "No", to the question: "Did you find your surroundings pleasant?" hardly conveys the same constructive criticism as does the statement: "Very ill patients ought not to be left with those who are convalescing", or "Grouping patients according to age might help to improve the environment". Here is one more example: To the question "Was the hospital ward quiet?" a patient might answer merely by writing "No". Is not the definite observation, "the ward was very noisy when the door of the kitchenette was left open" perferable to the first answer?

The number of times that these spontaneous, unsolicited comments occur are a good indication of the general impressions of the hospital which the patients receive. It will be noted quite frequently that certain comments are peculiar to one specific department. This may be an indication that *there* lies a particular problem for the administrator or for the director of nursing.

These mimeographed forms are put in envelopes and addressed to each patient on the day following admission. They are distributed by a junior member of the admitting department and are collected by the nurses, on the day of discharge, to be brought to the administrator's office. Patients are invited to take the letter home to reply at a later date if they have not had the opportunity to do so while in hospital.

Tabulation

Until last fall we had no system for summarizing and filing comments from these "Friendly Letters", as we call them. They were simply read, investigated when necessary, and then discarded. We began to wonder whether the project was worth while; we also had reason to doubt that all unfavourable comments reached us. How, then, were we able to determine, with some degree of accuracy, the quality of patient service in our institution? It was felt that a good system of tabulation would pay dividends in this matter as in everything else.

Consequently, a letter was sent to each of the departments participating in the project. We asked the nurses to co-operate with us by:

1. Encouraging the patients to make use of the forms, asking them also to seal the envelope as the information was considered confidential.

2. Requesting a 100 per cent return of all letters whether they had been used or not—since there are occasions where the patient is unable to write.

We promised that, for our part, we would prepare a summary for them every two weeks from all these letters and that it would be sent to the department. Because of the frequent rotation of student nurses, we felt that it would not be practical to wait longer than two weeks before making the reports.

The admitting department was requested to make a note of the exact number of letters distributed

(Concluded on page 82)

Life in a Ten-Bed Hospital

What can be done to help to ease
The matron's dire perplexities!

Ina Broadfoot, R.N.,
Director of Nursing Service, Manitoba Division, Canadian Red Cross, Winnipeg, Man.

FIRST of all, may I explain that what I shall relate is based on observing and studying some of the 10-bed hospitals in Manitoba. However, I am sure that the same situations can occur in small hospitals anywhere and the problems which may arise (taxing ingenuity and sometimes solved only by a monkey wrench) are similar too.

This year, two Red Cross hospitals were opened in Manitoba, eight beds at Arborg in January and ten beds at Fisher Branch in June. During the period we were preparing to open these hospitals and—to a far greater extent—during the time they have been open, we have learned a great deal about what is expected of the nurse administrator, or the nurse-in-charge. We can make a neat list of her duties and responsibilities on paper. We have the list and consult it often, for it is a valuable guide. But no outline, no matter how helpful it may be, can possibly anticipate all the matron may be called upon to do. Here is the outline we use—the duties of the matron.*

1. She must be a graduate of a recognized school of nursing and be an active practising member of the Manitoba Association of Registered Nurses.

2. All hospital management is under her control. This includes planning meals with the housekeeper and looking after special diets. She also takes charge of petty cash.

3. Responsibility for the standard of nursing care is one of her most important duties. In this capacity she assigns the various tasks to the general duty nurses.

4. She will be in charge of all hospital supplies and the ordering of such supplies—drugs, linen, food, et cetera—from division headquarters. She must keep an inventory of these. She also consults with the cook in regard to the local buying of food and issues requisitions to the cook for the actual buying.

5. The keeping of proper patient records, admissions, discharges, narcotics, other drugs, et cetera, is her responsibility and she issues accounts for services rendered to patients and is in charge of receiving payments.

6. It is also suggested that she issue written instructions when assigning various duties to the staff!

A Typical Day

Now let's see how this works out—as if we could all spend a day with the matron and find out the things which might happen!

Our heroine awakens at 7 a.m.

Courtesy, Wava McCullough, "Illustrated Handbook of Simple Nursing".

She doesn't need an alarm clock, for a loud noise or an unusual noise coming from above or below her ordinarily serves the purpose. In fact, the matron got in her first duty of the day four hours earlier at 3 a.m. This time a most peculiar noise awakened her, coming from the direction of the furnace. So she grabbed her bath robe and flew down two flights of stairs. She found the furnace room very hot and the noise, loud as well as unusual, orginating from the fan. Fortunately, although this was *not* included in her training as a nurse, she knew where the main switch was, and could turn off the fan.

Now it is 7.30 and she is dressed and having breakfast. While she is eating, the janitor bursts in to report that the septic tank is frozen or to inform her that the tap in the men's toilet is leaking and the basin is all stained.

By the time she has dealt with these minor catastrophes, the septic tank, the tap, the stoker, or at least started negotiations to have them attended to (and a great deal of conferring seems to be necessary before repairs of any kind are actually made) it is 8.30 and the babies in the nursery—fine, healthy specimens with good lungs—are crying. She starts into the nursery but she's way-laid by the part-time laundress who tells her that the washer is on the blink. Or perhaps it isn't the laundress at all, but someone else on the staff who announces blithely that the laundress just hasn't turned up.

So shortly after 9 a.m. the matron is in the laundry, tinkering with the washer. Perhaps for just a second or two she thinks fondly of her days in training, excellent training it was, too. It turned her out as such an efficient nurse, but it *did not*, unfortunately, include a course in the repair of mechanical objects.

At 10.05 that same morning, another crisis arises as cook tells the matron in dulcet tones that they need more potatoes. The matron knows they need more potatoes. She meant to get around to ordering them yesterday but with one thing and another, she just didn't manage to do it. So, according to Duty No. 6 in the list mentioned earlier, she gets out her requisition book to

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From an address presented at the Western Canada Institute for Hospital Administrators and Trustees held in Winnipeg, Man., October, 1950.

**Condensed for publication purposes.*

order supplies from a local food store.

A Matter of Potatoes

Now there are two local merchants from whom she might order potatoes —Mr. D. and Mr. X. Mr. X has had quite a few orders lately, so she phones Mr. D. This irate gentleman thinks it's just about time she phoned him. He complains that Mr. X. has been getting all the hospital business. What's more, he takes this opportunity to inform her, that he's fed up with the hospital—it's costing the community too much money. And further, he says, everyone in town tells him that there are too many nurses on the staff. Why just yesterday, he saw one of the nurses downtown for a *whole hour*. If they need nurses so badly, just what was that girl doing downtown for an hour? The matron with difficulty refrains from speaking her mind, and, finally, the potatoes are ordered. It's nearly 10.30 before she gets off the phone and then she actually has a little more than half an hour in which she is not bombarded with events above and beyond the duties laid down for her in the list.

At 11.09 the maid comes to her. The maid's cousin, it seems, is getting married. The big event is tomorrow and of course the girl wants the day off. The matron has a schedule of time-off, which she prepared one night just before she finally turned off the light. According to this schedule, tomorrow is the cook's day off and the maid generally takes over in the kitchen, under the supervision of the matron. Now work that one out.

In between times, in the hour uninterrupted by minor catastrophes, the matron has managed to "do up" Mrs. Jones and get an elderly patient, known to all as Grandpa Brown, up in a chair. Grandpa is heavy and quite helpless. Generally the matron gets the janitor or the handyman to help her but this always means running all over the place to enlist aid so this morning she tussles with Grandpa herself.

By 12.30 it is dinner time and the matron is quite ready for it. However, the meal is neither very hot nor very appetizing. The cook, who is tempermental, is in another of her depressed moods. If the matron should be so bold as to mention that dinner isn't what it should be, the cook dissolves in tears and, for the next two days, acts in the martyred manner she always assumes when she has a "mad on".

A Question of Visitors and Soup

At 1.15 p.m., two visitors arrive and identify themselves as the aunt and cousin of one Mrs. Black, a patient in the hospital. They say they know that it is early for visitors but they are going to a meeting at 2 p.m. and they knew it would be all right if they ran in for a minute now. Could they have another chair in Mrs. Black's room? And, oh, by the way, they brought Mrs. Black some home-made soup, could it be heated up right away? The cook is now off duty. The matron promises to heat the soup for Mrs. Black's supper. But the visitors want their poor sick friend to have it *now*. Will the matron enforce strict hospital routine and take a chance that the visitors will report, at their meeting, that the matron of *our* hospital is so lazy she can't even walk down the hall to the kitchen to heat up a bit of soup?

Between 2 and 3 p.m. the matron actually gets around to spending some time with the patients when she is all alone on duty. From 3 to 3.30 she's at her desk, trying to get caught up with the bookkeeping. The phone rings four times. One voice says sharply, "There's a smell from your sewer which we don't like". Another asks, "Why don't you get more gravel in your backyard?"

At 3.30 the bookkeeping has to be shelved abruptly. A maternity case is admitted. There is only one nurse coming in at 4 p.m. and it may be that she is a practical nurse rather than a registered nurse. The matron proceeds at once to action in the labour room.

I don't want to weary you, the matron has already reached that state, so I won't go through the rest of her day—a day which may last anywhere from 8 to 16 hours.

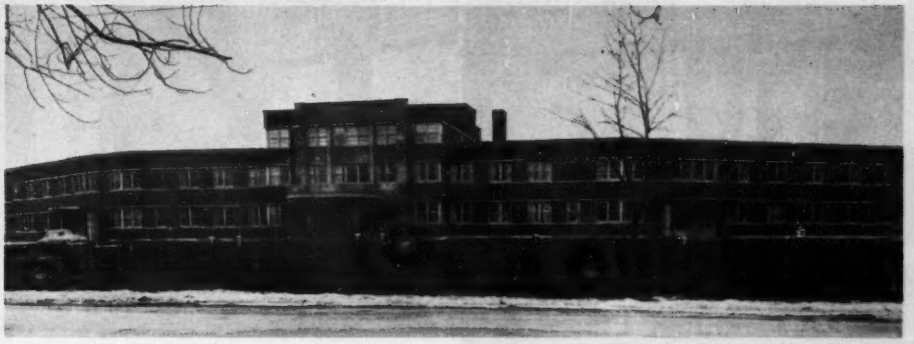
Matron's Responsibilities

So far, I have been speaking of "duties", the actual tasks the nurse is called on to perform. Let's look at responsibilities, the things for which the matron of a 10-bed hospital is held accountable. Nursing care for the patient is her first consideration. No matter what distractions there are, she must see to the patient's well-being. There is no need for me to outline the details of nursing care. But I would like to mention one thing a matron may be called on to do—give anaesthetics. The Red Cross Society in Manitoba

(Continued on page 86)

Un Résumé

La garde-malade en chef d'un hôpital de dix lits doit faire face à de nombreux problèmes. Non seulement elle doit s'occuper des malades mais aussi de plusieurs détails d'administration. Ses jours de congé sont limités, et pendant tout le temps qu'elle passe à l'hôpital ses services peuvent être requis pour des tâches variées comme des troubles de chauffage ou de plomberie. Les portes de l'hôpital sont toujours ouvertes; la garde-malade doit être là pour recevoir les nouveaux patients même si sa comptabilité n'est pas à date et la plomberie fait défaut. Les gens ont l'impression que ces gardes-malades ont peu de choses à faire vu le nombre restreint de lits. Rien n'est plus loin de la vérité car cet ouvrage est une épreuve constante pour l'initiative de la garde-malade. L'auteur suggère ensuite quelques solutions à ces problèmes. Le Bureau provincial d'hospitalisation pourrait envoyer un inspecteur pour visiter les lieux. La même organisation pourrait fournir de l'aide pour la comptabilité. Le département d'hygiène pourrait aider la garde-malade dans les problèmes qui ne lui sont pas familiers. Mais en plus dans la ville même il y a une source inépuisable d'aide. Ce sont les volontaires qui prennent à coeur l'avancement de leur hôpital. Le seul fait de sâvoir que quelqu'un pourrait l'aider en cas d'urgence serait un confort moral inappréciable pour la garde-malade en chef. Il est facile de comprendre pourquoi il y a si peu de gardes-malades qui s'occupent de ces petits hôpitaux. Le public en général devrait faire un effort pour comprendre ces problèmes et tâcher d'y remédier le mieux possible.—*Yves Prévost, M.D.*

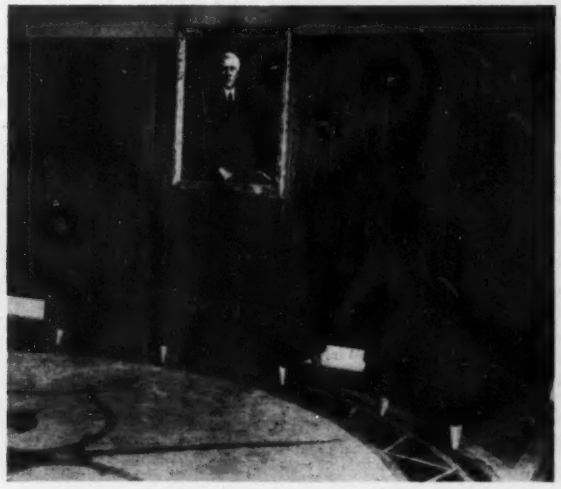


New Port Colborne General Hospital—

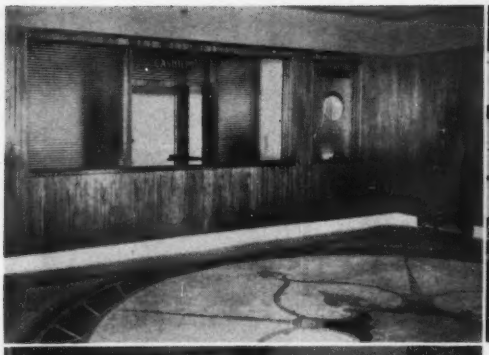
Planned to Meet the Needs of a Growing Industrial Area

ON February 10th, 1951, five years of planning, study, and community effort successfully culminated in the opening of the modern 70-bed Port Colborne General Hospital. Dedicated to the men of the district who gave their lives in World War II, the new hospital has a beautiful location near Lake Erie in the western portion of Lakeview Park, a well-landscaped area of five acres which was donated by the town.

The two and a half-storey building is of reinforced concrete with an exterior finish of brick facing backed by thick structural tile. An imposing and graceful entrance features Queenston limestone which frames attractive glass doors. Directly inside, is a glassed-in vestibule leading to the tastefully decorated lobby which has walls lined in rich mahogany plywood panelling, floors of terrazzo, and ceiling painted in a deep blue. Behind the information desk, along the east end of the room, is the large general office. A portrait in oils of Donald McGillivray, who



Portrait of the late Donald McGillivray, benefactor of the hospital, hangs in the main lobby.



Above left: View of lobby showing cash and information wickets. Note attractively designed terrazzo floor.

Above right: Sunny solarium with view across Lake Erie.

Left: A comfortable four-bed ward has wide windows and colourful décor.

bequeathed the residue of his estate for the construction of a general hospital in Port Colborne, occupies a place of honour on the west wall.

Surgery and Related Facilities

The surgical set-up on the main floor of the west wing offers complete operative services. The general admitting department is located here as well as several other rooms which may serve as recovery rooms or extra admitting space. There is provision for a physio-therapy room to be equipped at a later date, and the x-ray department is near by. The central supply room is in the west wing, as well as the splint room, and the doctors' locker room. The only services placed elsewhere are the laboratory, and basal metabolism and electro-cardiography rooms, which are located in the basement.

There are two identical operating rooms and an emergency operating unit. The overhead light runs on a track and has three speeds of intensity. It can be tilted at many angles. The emergency operating room has an orthopædic table specially designed for reduction and treatment of difficult fractures of the spine and long bones.

Dietary Department

Patients in the Port Colborne hospital receive their meals through a system new in hospitals—a patented procedure known as Mealpack. This process, similar to the one used on airplanes, vacuum-seals freshly prepared hot foods and has related components for protecting, distributing, and serving beverages, salads, and frozen deserts.

The bright, cheerful kitchen which dispenses the Mealpack is located on the first floor and overlooks the lake. The formula room, special diet kitchen, and dishwashing department are close by. Stainless steel equipment and many modern facilities and conveniences make this department a very efficient unit. Wood has been eliminated everywhere possible as a pest control measure, and floors and lower portion of the walls have been finished in terrazzo.

Staff and visitors receive their meals in a cafeteria consisting of two dining rooms which can seat between 70 and 90 people. Furnishings and decorative scheme give an air of lightness and relaxation to these rooms. A large mural covers an entire wall of the main section and colourfully portrays the growth and development of the locality from the days of the United Empire Loyalists.

For Mothers and Babies

The entire west wing of the second floor contains the obstetrical department and nurseries. There are 25 private, semi-private, and ward beds, and 22 bassinets. There is also a separate isolation unit designed to care for two infants. Located on either side of an examination room, two nurseries contain 10 cubicles each. Glass panels in the corridor walls permit visitors to view new arrivals.

Various Facilities

Pharmacy and central stores are centrally located in the basement. They occupy six rooms with the pharmacy next to the pathology de-

partment. The latter is contained in three rooms and when complete will be equipped with a blood bank and for work in hæmotology, urinalysis, biochemistry, and bacteriology. A well-equipped laundry is situated in the extreme east wing of the building.

Other Features

To the west of the main lobby, there is a small chapel in which religious rites of any denomination may be carried out or where quiet conferences may be held in time of serious illness or death. Its walls are of the same mahogany panelling as in the lobby, with ceiling of Carribean blue.

Two large, bright solaria are located on the second floor in the east and south wings of the building. They afford patients a beautiful view over Lake Erie and the eastern portion of the park. The decoration scheme here is colourful and furnishings convenient and comfortable.

The nurses' call system has two means of communication. A patient can call the nurses' station by simply pressing a button at the side of his bed. This turns a light on over the door of his room and at the same time a buzzer rings at the utility stations and registers on the annunciator in the nurses' station. By pressing a key, the nurse can speak to the patient over the audio-sound system.

The danger of fire has been greatly minimized in the new building which has terrazzo floors and structural tile partitions. As well, all interior door frames are of steel.

A special ventilating system has been installed for the operating rooms. Air is passed over an electro-precipitrone unit which removes 95 per cent of all dust particles.

In the nurses' central work room, the terminal sterilization method is employed. By this method all sterilization of instruments, dressings, et cetera, is done at one point under strict supervision. From this workroom all sterile goods pass to the central supply room where they are wrapped, catalogued, and stored. They are carefully checked when issued from central supply room and again when they are returned, thus reducing loss and error to a minimum.

The hospital is heated by a forced hot water system, using radiators which are recessed into the walls under the windows. The radiators are of a type which heat by connection as well as radiation. These features together with double glazed windows help to create greater patient comfort with minimum heating cost.

The over-all cost of hospital construction is estimated at $800,000, or at about $11,000 per bed. Equipment was purchased for approximately $175,000.

Filling a need long felt in the area, the new Port Colborne General Hospital has been erected in great measure through the efforts of the citizens of the district. In return, their new institution has every facility to serve them well. Planning and construction of the new building was under the guidance of Captain R. Scott Misener, chairman of the hospital board; architect was Chester C. Woods of Toronto.

Right: On opening day visitors inspect shiny new cafeteria.

Below left: Gleaming kitchen equipment used in new mealpack food service.

Below right: One entire wall in the dining room is covered by a sweeping mural which dramatically portrays growth and development of the area.

A New Method of Payment for HOSPITAL CARE

G. W. Myers, C.A.,
Executive Director,
Saskatchewan Hospital Services Plan,
Regina, Sask.

IT IS the experience of most hospital administrators that a considerable part of hospital operating costs will remain at about the same level regardless of fluctuations in the number of patients occupying beds. The emptying of five or six beds in a 100-bed hospital, for example, may not result in a decrease in salaries, light, heat, depreciation, and other expenses of a relatively fixed nature. Such fixed expenses have been described as the "readiness-to-serve" cost of hospital operation. Variable expenses—that is, expenses which vary in direct proportion to occupancy—generally represent a much smaller proportion of the total cost than do fixed expenses.

The amount of revenue derived from charges for in-patient care on the other hand is closely related in most cases to hospital occupancy. Any change in the number of patients usually means a corresponding rise or fall in the volume of charges to patients or insuring agencies. The balancing of revenues which fluctuate with changes in occupancy from month to month against expenses which do not fluctuate to the same extent is one of the problems frequently encountered in its most acute form in small hospitals since small hospitals generally experience the greatest variations in the percentage of beds occupied.

System of Payment

At the beginning of 1951, the Saskatchewan Hospital Services Plan, in accordance with agreements reached in discussions with the representatives of the Saskatchewan Hospital Association and the Catholic Hospital Conference of Saskatchewan, introduced a system of payment for hospital claims which may meet part of this problem. Lump sum payments, which do not vary with occupancy, are forwarded on a semi-monthly basis to all public general hospitals in Saskatchewan. For SHSP beneficiaries these lump sum payments, in most cases, represent slightly more than the "readiness-to-serve" cost per patient day. Since the majority of hospitals in the province have relatively few patients who are not SHSP beneficiaries, these semi-monthly payments generally come close to meeting total "readiness-to-serve" costs for in-patients. Cheques covering such payments are mailed on or about the tenth and twenty-fifth of each month.

In addition, the Hospital Services Plan makes payment on the basis of accounts submitted by hospitals for individual patients at per diem rates which are estimated to represent slightly less than the amount of variable expenses. The following are the per diem rates which are used by Saskatchewan public general hospitals when billing the Plan under this arrangement for care rendered to SHSP beneficiaries.

Rated Capacity of Hospital	Adults & Children	Newborn
50 or more beds....	$2.00	$1.00
15 to 49 beds	1.75	1.00
Less than 15 beds	1.50	1.00

For purposes of arriving at the amount of semi-monthly payments, each hospital in the province submits to the Plan a budget based upon a uniform system of accounting. In most cases, budgets are prepared at the beginning of the calendar year, but may be prepared at other times whenever it is felt necessary by a hospital or the Plan to renegotiate rates of payment.

Uniform System of Accounting

An average per diem rate based upon estimated occupancy and estimated operating costs is first of all determined from the information in the budget, supplemented by such discussions with hospital authorities as may be necessary. The greater part of this average per diem rate is incorporated in semi-monthly lump sum payments, while the remainder is paid to hospitals when accounts are submitted.

The method of determining the amount of the semi-monthly payment may be illustrated by an example based on a hypothetical hospital in the 15-49 bed group which has estimated its patient days for the coming year as shown in Fig. 1.

The hospital in this example has budgeted for an operating expenditure during the year of $61,084.23. Its budget indicates that it expects to derive most of its revenue from public ward charges. The hospital has estimated that its charges for private rooms will exceed public ward rates by $2.50 per patient day and in the case of semi-private rooms by $1.50 per patient day. The hospital has also provided in its budget for estimated revenue from the sale of drugs and from outpatient services and for losses due to rebates, courtesy, free services, and bad debts.

On the basis of information in

Fig. 1

Estimated Patient Days by Class of Accommodation and Authority Responsible for Payment

Accommodation	Adult and Children Days			Newborn Days
	Total	SHSP	Others	(all SHSP)
Total	9,511	9,092	419	589
Private	528	498	30	.....
Semi-private	856	806	50	.....
Public or Nursery....	8,127	7,788	339	589

An address presented at the Saskatchewan Hospital Association Convention, Saskatoon, Oct., 1950.

the hospital budget the average per diem rate for adults is computed as in Fig. 2. The first item in this calculation is the estimated net operating expenditure for the budget period. Since this figure includes the cost of providing certain services outside the Plan's schedule of benefits, such as the extra cost of private and semi-private rooms, special drugs, and out-patient services, revenue from the these sources is deducted when computing the amount which should be met from an average public ward rate. Estimated revenue from newborn patients at a fixed rate of $2.00 per patient day is also deducted, since it will be paid in a separate rate. Allowance is made in the calculation for losses due to rebates, courtesy, free services, and bad debts.

Fig. 2

Estimated Net Operating Expenditure			$61,084.23
Deduct Revenue from:			
Private Rooms	528 days @ $2.50	$1,320.00	
Semi-private Rooms	856 days @ 1.50	1,284.00	
Newborns	589 days @ 2.00	1,178.00	
Sale of Non-SHSP Drugs		302.00	
Out-patient Services		1,000.00	
		$5,084.00	
Less Rebates, Courtesy, Free, Bad Debts		400.00	
			4,684.00
Estimated Expenditures to be met from Public Ward Adult Rate			$56,400.23
Average Adult Rate Required—*Expenditure as above $56,400 divided by 9,511 patient days (Excl. Newborns)*			$5.93
Deduct Per Diem Payments for Adults			1.75
Amount to be Included in Lump Sum Payments (Exclud. Newborns)			$4.18

Fig. 3

Lump Sum Payments by SHSP:			
9092 SHSP adult days by	$4.18		$38,004.56
589 SHSP newborn days by	1.00		589.00
			$38,593.56
Per Diem Payments by SHSP:			
9092 SHSP adult days by	1.75	$15,911.00	
589 SHSP newborn days by	1.00	589.00	
			16,500.00
Total SHSP Payments			55,093.56
Other Revenue			
Non-SHSP In-patients—419 days by	$5.93	2,484.67	
Private Rooms 528 days by	2.50	1,320.00	
Semi-private rooms 856 days by	1.50	1,284.00	
Sale of Non-SHSP Drugs		302.00	
Out-patient services		1,000.00	
		6,390.67	
Less Rebates, Courtesy, Free, Bad Debts		400.00	
			5,990.67
Total Estimated Revenue (Equals total estimated operating expenditure)			$61,084.23

Average Adult Rate

In the example, an estimated amount of $56,400 to be met from an average public ward adult rate is divided by 9,511 adult patient days, to determine an average adult rate of $5.93. This is the figure which would be used by the hospital in billing agencies such as the Workmen's Compensation Board which pay hospitals at SHSP rates. It would also be the rate used by the Plan in preparing statements which are forwarded to patients to show amounts paid on their behalf.

Since the hospital in the example is in the 15-49 bed group, $1.75 per adult patient day and $1.00 per newborn day would be paid on the basis of accounts submitted by the hospital. The remainder of the per diem rate, or $4.18 per estimated adult patient day and $1.00 per estimated newborn day, would be incorporated in lump sums paid to the hospital at regular intervals. As previously mentioned, these lump sums which are based on the budget would remain the same regardless of fluctuations in occupancy.

Total Hospital Revenue

On the basis of the budget, total hospital revenue for the year would be derived from the following sources indicated in Fig. 3. In the event that hospital occupancy is either above or below the level estimated in the budget, fluctuations in total income will be less marked, and will be closer to fluctuations in expenditure than when payments by the Hospital Services Plan were made on the basis of inclusive per diem rates. This is due to the fact that total lump sum payments, amounting to $38,593.56 in the example, remain the same regardless of the number of patient days.

Method of Payment

The present system is the third method of payment for hospital care which has been used by the Plan since it commenced operations in 1947. The first method, which was employed during the calendar year 1947, was one in which inclusive per diem rates were determined by what was known as the "point system", that is, an assessment of the facilities available in each hospital. The amount payable to each hospital per patient day was computed by applying a mill rate to the total points which were allotted as a result of an inspection of the hospital's facilities. The schedule of points used in the inspection was based on a proposal by Dr. Harvey Agnew, which was published in *The Canadian Hospital* of November, 1943. It was decided to discontinue the use of the "point system" as a basis for payment at the end of 1947, due to the fact that the cost of providing various services in different hospitals could not be precisely related to a schedule of points reflecting adequacy of facilities. It can be

(Concluded on page 94)

Devoirs et Responsabilités d'un Administrateur d'Hôpital

Part II

R. Fraser Armstrong,
Superintendent,
Kingston General Hospital,
Kingston, Ont.

LES statuts et les règlements sont indispensables à toute bonne administration. Ils peuvent se diviser en deux parties: fondamentaux et particuliers.

Les règlements fondamentaux peuvent se résumer en trois phrases concises:

1. Le bureau de direction est responsable de l'administration de l'hôpital dans son ensemble et dans chacune de ses grandes divisions;

2. L'administrateur est responsable au bureau de direction, de l'administration de l'hôpital dans son ensemble et dans chacune de ses grandes divisions;

3. Le bureau de direction, le personnel médical et l'administrateur sont chacun, pour leur part, responsables de l'exécution des directives acceptées en collaboration et codifiées dans les statuts et règlements.

Lorsque les règlements fondamentaux sont déterminés et acceptés, il reste ceux d'ordre particulier. Ces derniers, à leur tour, peuvent se diviser en deux parties: médicaux et administratifs.

Règlements Médicaux

Le but de l'organisation du personnel médical, organisation entièrement soumise au contrôle du bureau de direction, est de définir et de codifier les règlements qui permettront à ce corps de se gouverner par lui-même dans les limites des statuts et règlements. Ces règlements doivent être bien faits, très complets et couvrir toutes les procédures requises au bon fonctionnement du corps médical. Ils réduiront au minimum, l'intervention du bureau de direction dans son fonctionnement. Le corps médical doit reconnaître et accepter que toute décision finale doit venir du bureau de direction, y compris l'administrateur, et prévoir la solution des mesures urgentes, par l'adminstrateur, moyennant certaines consultations rapides approuvées à l'avance. Ainsi, bien des mésententes déplorables entre le bureau de direction et le corps médical, seront évitées.

Règlements Administratifs

En ce qui concerne les règlements administratifs, il ne faut s'arrêter qu'aux essentiels. Définir clairement l'organisation du personnel, les responsabilités des chefs par rapport à certains officiers, celles de ces officiers par rappart à l'administrateur et celles de ce dernier par rapport du bureau de direction.

Relations Entre les Autorités Administratives

Une des principales responsabilités de l'administrateur est d'entretenir de bonnes relations entre les membres du bureau de direction, entre le corps médical et lui-même, entre les membres du corps médical et ceux du bureau de direction. Ces relations ont été l'écueil où s'est heurtée plus d'une administration hospitalière. Sans doute, il n'est pas un administrateur qui n'a eu ou qui n'aura, durant sa carrière, à déplorer des difficultés de relations avec ces organismes vitaux dans un hôpital. Etant donné ce qu'est la nature humaine, ils sont inévitables. Ils sont plus fréquents, lorsque les relations d'autorité sont mal définies et pour leur efficacité, elles doivent être déterminées en collaboration avec le bureau de direction, le personnel médical et l'administrateur.

Une Organisation Hospitalière

En établissant les principes fondamentaux d'une organisation hospitalière, il faut savoir choisir entre une administration par des comités ou un bureau de direction dont les décisions sont exécutées par un administrateur.

La tendance actuelle, surtout dans les petits hôpitaux, est d'opter pour le mode des comités. Vu les dangers inhérents à ce mode d'administration, il ne faut l'accepter qu'avec grande précaution. Là, où les responsabilités sont définies et bien précisées, les résultats sont meilleurs que là où elles sont perdues dans un ensemble de comités administratifs. La rapidité, dans l'exécution du travail, est importante; le retard, causé par les délibérations administratives, est parfois très coûteux. Il serait malheureux que l'administrateur devienne un simple secrétaire de comités, ce qui diminuerait son rendement dans l'organisation hospitalière.

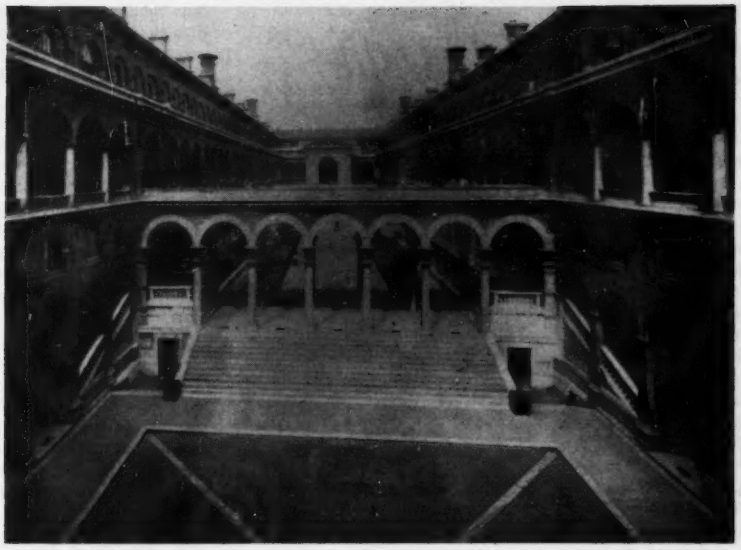
Le mode de comités fait perdre, dans des détails administratifs, un temps précieux aux membres qui les composent, et influence vers une délégation d'autorité aux chefs de département. Et ce qui est plus déplorable, c'est que la responsabilité de l'administrateur ne vient plus directement du bureau de direction, mais des divers comités.

Le bureau de direction doit s'assembler régulièrement une fois le mois et reviser toutes les phases administratives de l'hôpital. L'administrateur, en cas de décisions urgentes, doit pouvoir recourir à un comité consultatif. Cependant, il est nécessaire de surveiller le fonctionnement de ce comité qui doit être reconnu comme consultatif et non comme un petit comité administratif qui assume les responsabilités du bureau. Entre les assemblées du bureau, l'administrateur doit avoir la liberté de prendre des initiatives, ce qui, dans quelques hôpitaux, est du ressort du comités.

Les Comités d'Aviseurs

Il y a beaucoup de différence entre les précédents et ceux-ci. Les critiques impliquées aux précédents ne s'appliquent nullement aux comités d'aviseurs. Ces derniers ont leur place marquée dans l'organisation hospitalière. L'un des plus impor-

D'après un discours donné le 27 juin au Seizième Congrès des Hôpitaux Catholiques de la Province de Québec, organisé par le Comité des Hôpitaux du Québec.



L'Hôtel-Dieu Among Famous Sights to Visit in Paris

This year the city of Paris is celebrating its one thousandth anniversary and will play host to many eager and enthusiastic visitors. Of special interest to hospital people is the famous and awe-inspiring l'Hôtel-Dieu. Situated in the shadow of Notre Dame Cathedral, this hospital, whose history is even older than the city, stands as a monument to the advancement of medical science.

Although the present structure is modern, records of l'Hôtel-Dieu date back to 829 A.D. and historians believe it was founded between 649 and 660 A.D. Originally, the hospital was a charity institution sponsored by the church; later, about 1500, it became a city charity hospital.

In the early middle ages it was truly a House of God and one of the most progressive hospitals of Europe. Homeless patients were brought in from the street and given a place in bed with other patients (as was then the custom), a wool blanket to cover him, and a linen turban for his head. The hospital laundry was washed in the Seine and a bakery, farm, and herb garden were maintained by the hospital. During the eighteenth century this hospital, as well as all others in Europe, reflected the appalling conditions and apathetic attitude which were prevalent during that period. Today, however, the only reminders of that time are a few wards and some arches in the courtyard. Now l'Hôtel-Dieu numbers among the finest and most progressive hospitals of the world.

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tants est le comité d'aviseurs médical et chirurgical. Ce comité fait, au bureau de direction, les recommandations et les réclamations du corps médical; ce qui implique les avis, règlements ou décisions ayant trait au personnel médical, à l'organisation clinique de l'hôpital, à la répartition du travail professionnel et scientifique; le tout en harmonie avec les directives codifiées dans les statuts et règlements. Ce comité a pour fonction de rendre officiels, les avis et recommandations aux deux partis: le personnel médical et le bureau de direction.

La principale responsabilité de l'administrateur est de maintenir l'équilibre entre le coût des soins médicaux et scientifiques donnés aux malades et la capacité financière de l'hôpital. D'une part, il doit continuellement chercher à procurer aux malades et aux médecins un service de plus en plus perfectionné et complet. D'autre part, il doit continuellement s'efforcer d'augmenter les revenus de l'hôpital et de réduire les dépenses inutiles. Comme l'institution doit aller de l'avant, il ne devrait pas se voir arrêté par une situation financière inquiétante. Ce qu'il doit poursuivre, c'est un avancement régulier, l'obtention de subsides pour soutenir cet avancement et obtenir le plus de rendement possible des subsides.

N'est pas satisfaisante l'administration qui restreint les opérations financières aux dépens du progrès, et ne l'est pas davantage, celle qui entraîne l'hôpital dans des dépenses qui mettent sa situation en péril et finalement, compromet la valeur du service des malades. Ni la gêne, ni la prodigalité ne doivent prévalorir. L'administration satisfaisante est

(Continued on page 92)

The Fight for Mental Health

J. D. M. Griffin, M.D.,
Medical Director,
The Canadian Mental Health Association,
Toronto, Ont.

IT is now generally acknowledged that mental illness has become not only a great human crippler but also our number one public health problem. The mentally ill, at any one time, occupy nearly as many hospital beds as do patients suffering from all other types of disease put together. Careful surveys indicate that poor mental health causing at least partial disability affects more than 10 per cent of the population. The cost of operating Canadian mental hospitals is amounting to more than 35 million dollars annually. The hidden and indirect costs of poor mental health are astronomical. The existing hospital and clinical facilities, although gradually improving, are still very far from being adequate to meet the need. The number of medical and ancillary professional personnel properly trained in mental health is discouragingly low. Those receiving training now cannot make up the deficiency. The amount of research into the preventive and curative aspects of psychiatry is still embryonic compared, for example, with industrial research.

Mental Health Organization

The Canadian Mental Health Association has been operating as a national voluntary organization for 33 years. Founded in 1918 by the Duke of Devonshire, as the Canadian National Committee for Mental Hygiene, it established the principle of co-operation between citizens and scientists in the fight for mental health. The objectives of the association remain as they were in 1918: to fight for mental health in all its aspects; to prevent mental illness; and to promote good mental health.

During the last 30 years under the general direction of Dr. C. M. Hincks, and without fanfare or publicity, much has been done to achieve these objectives. Careful surveys of mental hospitals and clinics have been made in all provinces. Funds were secured to initiate, through co-operation with Canadian universities, the training of key personnel and establishment of basic research.

A substantial program of public education and a bureau of mental health information were organized. While a list of specific accomplishments would be far too lengthy for such a summary as this, it is a fact that, largely through the pioneering efforts of this organization, the following significant developments have occurred.

1. Mental hospitals have increased their bed capacity from 9,000 to 50,000.

2. Special training school and educational facilities for mentally defective and retarded children, which were almost non-existent, now have facilities for about 20,000 children.

3. Mental health clinics, first established on a demonstration basis by the organization, now number over 30.

4. Several important mental health agencies were started by the organization and later carried on by other sponsors. These include: The Institute of Child Study, University of Toronto; The Mental Hygiene Institute, Montreal; and Bureau of Vocational Guidance, Ontario College of Education, Toronto.

5. The organization was the first to demonstrate the value of careful psychiatric and psychological screening in choosing immigrants coming to Canada, and in World War II, selecting personnel for the armed services.

Since World War II, it has become increasingly evident that the general public is showing more and more interest in this difficult field. Consequently, in 1949, the Board of Directors decided to re-organize in an effort to develop a real citizens' movement in mental health. To this end the name of the organization was changed to the Canadian Mental Health Association and the By-Laws were amended to permit the establishment of provincial divisions and local branches. Nova Scotia, New Brunswick, and Saskatchewan now have such divisions. A strong Scientific Planning Committee was formed, representing all provinces, with Dr. D. Ewen Cameron, Professor of Psychiatry, McGill University, as chairman. The committee has been studying the present program of the association and making plans for extending the work, especially in the field of research and public education.

Present research, being conducted in co-operation with the University of Toronto, includes a community project in Forest Hill Village, a study of shy and recessive children, and work in the field of human relations in industry.

In connection with public education, the association is sponsoring Mental Health Week, May 1-7, in order to develop "participant consciousness" in people. This will coincide with a drive for dollar memberships.

As the new organization grows it is confidently anticipated that an interested and enlighted public will help to promote developments and progress which would not otherwise be possible.

Today, with the tempo of living quickening, the trend toward urbanization, the stress and strain of impending international hostilities, the increasing numbers of the aged, and the tendency toward fragmentation of the basic institutions of family and community, the problems of mental health are more urgent and more personal than ever before.

Our association is a charter member of the World Federation for Mental Health and two of the staff are on the executive of that body. Our national president is Dr. Jonathan C. Meakins, C.B.E., F.R.C.P., LLD. The chairman of the national board of directors is John S. D. Tory, K.C. The national office is located at 111 St. George Street, Toronto, and any enquiries regarding our work will be welcome. ●

Let's Not Have a Fire

R. B. McLean,
District Fire Prevention Officer,
Department of Veterans' Affairs,
Winnipeg, Man.

FIRE prevention has, in the past, been a rather subdued subject with too little public interest displayed until disaster hits. This is often followed by an attack on the administrative authority. Thick and fast fly questions such as: Why wasn't this done? Why were we not prepared? In most cases, it would appear that a scapegoat is sought and then all is well until the next fire. It is a regrettable situation but true so, in the first place, let's not *have* a fire.

Fire prevention and fire fighting are sciences. They require study, training, and application, to be carried out efficiently. Fire prevention, itself, is the art or science of making life and property safe against fire. You cannot remove the possibilities of fire, but you can remove the probabilities.

Fire fighting, of course, is the science of waging a physical war against the advance of an enemy who asks or gives no quarter. I am not inferring that one must necessarily be a professional fire fighter to combat a fire anymore than one must be a carpenter to drive a nail, or a plumber to fix a leaky tap.

Kinds and Causes of Fire

Various materials and objects can be the source of fire. Generally, they can be grouped under three classifications.

1. Ordinary combustible materials such as wood, paper, textiles, et cetera.
2. Oil, grease, wax, paints or lacquers.
3. Electrical machinery and apparatus, such as motors, switch panels, and wiring.

In hospitals all three of these sources may be found, as I shall endeavour to point out.

It is realized, of course, that in order to prevent fire one must understand its causes. The careless smoker is a very obvious cause and very difficult to control. Control can be established only by the full co-operation of the medical and nursing staff who are direct supervisors of patients' activities.

We in the Winnipeg District of D.V.A., have printed regulations which are issued to all patients on admission. They give a brief outline of privileges and prohibitions which, while admittedly not 100 per cent effective, serve as a guide to the conscientious. The more fractious or rebellious types, with which we are sometimes blessed, are governed by the nursing staff's rigid supervision.

Smoking as a Hazard

In danger areas where it is advisable to prohibit smoking, signs should be posted to that effect and the regulation enforced to the full extent of your authority. However, I would warn against posting signs indiscriminately as this gives rise to an attitude of indifference. Thus, smoking would be carried on with the same disregard in an area where a serious fire hazard may exist as in an area where you merely desire to reduce the amount of tobacco ashes on the floor. Sitting rooms and balconies should be provided with enough ash receivers (even in excess of normal requirements) to discourage the nasty habit of some individuals who deposit burning cigarette or cigar stubs behind the furnishings rather than move to provide themselves with an ash tray.

Sources of danger from fires (apart from the careless patient or staff smoker) may be found in: defective heating equipment, defective chimneys, inflammable liquids, misuse of electricity, rubbish, sparks on roofs, lightning, storage areas, operating theatres, and spontaneous ignition. These by no means cover the entire field but are the common causes and areas. I shall go over them briefly in order that you may learn just how they create a hazard and more important how to avoid the cause in the first place. Never lose sight of the fact that fires don't happen—they are caused. Fire once started will take hold and destroy everything known to mankind including man himself.

Defective Heating Equipment

Improper insulation, insufficient separating space from surrounding combustible materials, and disrepair are dangers in regard to equipment. To avoid fires from these sources, regular inspection as to conditions, and assurance that all installations are made in accordance with Underwriters' Specifications, will eliminate hazards. Cleanliness and common sense must also be applied.

Defective Chimneys

Loose bricks and mortar can cause an opening into the concealed spaces between walls, ceiling and roof; and pieces of timber, roof joists, floor joists, et cetera, entering into chimney wall also create a hazard. Fire from this source can be avoided by adequate inspections and necessary adjustments or required repairs.

Inflammable Liquids

Odd as it may seem, humanity has not yet learned to respect the strange and wonderful power of some inflammable liquids. Gasoline, for instance, has an explosive power per imperial gallon that is equal to 100 pounds of dynamite. When we speak of it in that way we get a vivid idea of its danger. It may sound exaggerated, however, to go further and say that a gallon of this liquid when vaporized through your carburetor will drive a moderate-sized motor vehicle twenty-three to twenty-five miles, a heavier vehicle sixteen to eighteen miles, and so on. Still, people will permit the use of this liquid around homes for dry cleaning purposes, little realizing that when mixed with air in proper proportion and ignited, it can literarily blow the house off its founda-

An address presented at the Western Canada Institute for Administrators and Trustees, Winnipeg, Oct., 1950.

tions. To avoid any such catastrophes reduce inflammable liquids to an absolute minimum and store them in a place of safety.

Misuse of Electricity

The misuse of electricity is the cause of numerous fires annually. It will be noted that I said misuse. Electricity, properly harnessed and used as intended, presents no greater fire hazard than the fire in the heating systems or cooking stoves but if it is neglected or overworked, one can expect trouble. The more frequent causes of electrical fires may be listed under three general classes: arcs, sparks, and overheating.

Over-fusing should be avoided. If your requirements call for a fuse of 15 ampheres, that is the type to use. Please keep in mind that if a fuse burns out, there is a reason—find the reason rather than increase the ampherage of the fuse. You are not getting twice the value you may think by substituting a 30 amphere for a 15 amphere (even at the same price) but you are most certainly asking for trouble. Fuses are the safety valves of an electric system and should be of the proper size at all times. The increasing of fuse ampherage may be compared with tying down the "pop" or relief valve of a steam pressure system.

It should be insisted that only qualified persons install and supervise the maintenance of electrical equipment. Such precautionary measures should go a long way in preventing fires of an electrical source.*

Accumulated Rubbish

Necessary and accepted refuse associated with hospitals, such as newspapers, magazines, excelsior, packing waste, should be collected and stored in metal containers which have close-fitting metal lids or covers. A system should be devised for emptying these containers daily. If there is no incinerator on the grounds for the disposal of these accumulations, they should be removed to an area apart from the hospital where they can be safely burned under the supervision of a competent person. At all times, avoid the fire hazard of accumulated rubbish, by getting rid of it quickly.

**At this point of his address, Mr. McLean vividly demonstrated the possible results of overloading a circuit by inserting a fuse of too great ampherage, and of placing pennies or wire jumpers in fuse sockets.*

Sparks on Roof

This hazard is considered worthy of attention especially where roof construction is of wood and cedar shingles. Sparks are much more common in rural areas in summer months than in urban centres where electric stoves are in the majority. However, any spark coming into contact with a shingle roof can be considered a fire hazard. The condition of the roof will influence the extent of danger. Dry shingles curled at the edges provide a pocket for a spark. With a gentle breeze to fan it into flame, a roof fire can result which under certain circumstances may mean the destruction of an entire institution.

Lightning

Lightning as a fire cause is not uncommon. Although we are unable to prevent lightning itself, we *can* control its damage by the installation of approved types of conductors designed to conduct lightning charges safely to the ground.

Spontaneous Ignition

Volumes could be written on, and hours devoted to, the subject of spontaneous ignition, or what is commonly and erroneously called "spontaneous combustion". However, I shall condense the facts to a few pertinent remarks.

Storage areas containing cleaning equipment are likely places for spontaneous ignition to take place. This is due to the fact that most cleaning preparations used for floors, furniture, and so on, contain drying or oxidizing oils which are hazardous in combination with fibrous materials such as dust cloths, floor mops, et cetera.

We do not give much thought to the chemical action of fire when we apply a match or other means of ignition to a combustible material—we merely accept the result. There is little, if any, chemical reaction between most combustibles and the oxygen of the air at ordinary temperatures. However, when heated sufficiently (by the application of a match or other means of increasing temperature) reaction begins and continues until the combustibles reach a temperature at which the action becomes self-sustaining.*

This temperature level is known as the ignition point or ignition temperature. When the primary source of heat is chemical action due to the combustible itself or between the combustible and the supporter of combustion, the process is known as spontaneous heating. If ignition temperature is reached, the process is called spontaneous ignition, or combustion. Fires from the spontaneous ignition of cotton waste or rags which have been used for wiping up linseed oil or paint are of frequent occurrence.

The recognized method of avoiding dangerous spontaneous heating lies in keeping equipment clean, and in providing air-tight containers for storing wiping cloths and mop-heads that may be soiled with cleaning or polishing preparations. The hanging of mops with heads off the floor allows possible accumulations of heat in this equipment to dissipate.

Ensure that storage cupboards are not subject to overheating due to contact with heat ducts, steam pipes, et cetera, and where possible provide thorough ventilation.

Other sources of fire that can be guarded against by regular inspection, caution, and cleanliness, are:

Electrical Appliances. Contacts and wires should be in good repair, motors and fans free of lint, dust, et cetera.

Kitchen Hazards. Stove clearance from combustibles, adequate canopy over stoves, and ranges cleaned regularly.

Labs and Dispensaries. Chemical storage care. Bunsen or other burners should be properly installed. (Gas used for burners must be located in a separate well-ventilated building.)

Operating Rooms. Safe practice in accordance with code for operating rooms.

**Mr. McLean demonstrated spontaneous ignition by using two common substances found in all treatment institutions and, in a large number of cases, in the home medical kit—glycerine and potash permanganate. He further outlined the cautions to be exercised in pharmaceutical stores to ensure that these and similar acting combinations are disassociated for safety reasons.*

(To be concluded next month)

SURFACE-CHROMICIZING*

When gut is chromicized after strands are spun and dried, chrome concentration is very high in surface layers and relatively low in the core. Inner core is digested rapidly—the highly chromicized periphery survives for prolonged periods.

ETHICON TRU-CHROMICIZING

Individual ribbons of gut are soaked in chrome bath before they are spun into strand, permitting uniform deposition of chrome. The strand thus has the same chrome content from periphery to center.

Why Ethicon's Tru-Chromicizing Process

MEANS BETTER SUTURES

The fate of the absorbable suture after implantation and wound closure, and its reactions in the host, are the ultimate test of the suture's quality and dependability.

Today chromicized gut is widely used because of its resistance to digestion until healing is accomplished. In this aspect, the chromic suture must possess these attributes:

1. Sufficient chrome content to withstand premature digestion.

2. Chrome concentration must not be so excessive that fragments of the suture resist digestion and persist in tissue. This condition frequently leads to knot extrusion.

In order to obtain a product having the highest possible degree of uniformity, Ethicon chromicizes raw gut strands in the ribbon stage. This more meticulous process was named Tru-chromicizing. The alternative method, used by others, called surface-chromicizing, involves the dipping of the finished, spun and dried suture strand in a chrome bath. These are the results of the two methods:

Surface-Chromicizing

In enzyme solution, the core of most surface-chromicized gut digests readily, leaving a hollow cylinder which separates into ribbons. This cylinder may be excessively resistant to enzyme action and remain as an undigested foreign body indefinitely.

Tru-Chromicizing

Ethicon Tru-chromicized gut exhibits uniform enzyme resistance throughout digestion. It digests from the surface inward, and retains its integrity as a unified suture until dissolution approaches completion.

Total digestion eliminates the danger of knot extrusions and sterile stitch abscesses.

What Tru-Chromicizing Means

1. Less interference with healing through minimized foreign body reaction.

2. High tensile strength of suture retained for the healing period, followed by complete absorption.

3. Uniformity in those physical and physiologic characteristics essential to accurate surgical technic.

***To illustrate this comparison, small laboratory trays are used. In commercial production, surface-chromicizing is done under tension. Both processes are performed in large vats.**

ETHICON *Sutures*

Johnson & Johnson LIMITED MONTREAL

Food and Its Service

Sponsored by the Canadian Dietetic Association

Reducing Costs Through Efficiency

Marjorie Kennish,
Mount Allison University, Sackville, N.B.

THE institutional food service of today, whatever its type, is regarded in the same manner as any other business enterprise, whether it is engaged in the production and service of food for gainful profit or for service alone. It must be run in an efficient manner if it is to continue in successful operation and the balance sheet should show that it is functioning "in the black".

Many external factors influence modern food service. While some of these cannot be held in check by the food service director, others can, and should be controlled, thus raising efficiency of operation to a higher level. Therefore, this article will emphasize cost, both visible and hidden, and will endeavour to show the relationship of efficiency to cost.

It has been pointed out by A. M. Macfarlane[1]* that a food service director has certain goals. These are:

1. The production of the best food for the money available;
2. A layout which will simplify work and motions;
3. A type of housekeeping which will set a high standard of sanitation;
4. Labour, food, and operating costs which will meet the budget;
5. Enough volume of business to satisfy the individual operation;
6. The best training programs possible;
7. Low rate of labour turnover;
8. Happy and efficient employees;
9. Customer patronage and good will at a maximum level.

In this period of rapidly rising prices and costs, efficient operation is a necessity especially in institutions where food service forms such a large part of the total budget. In order to increase efficiency, the food director and her assistants should make a careful analysis of their individual situation before contemplating action. This will mean a careful study of costs with emphasis on good human relations and good service. The tools required for such a study are a thorough knowledge of all phases of operation, time, paper and pencil, an open mind, and the ability to "think-through" situations. The changes to be made should follow a pattern which will bring long-term results. Follow-up reviews can be made from time to time as conditions change.

Observations of all phases of operation should be made under actual production conditions, within definite periods of time. Miss Macfarlane suggests that often employees will offer good constructive criticism, if they are taken into confidence, as they do the actual work and have a thorough knowledge of the problems involved in the performance of their duties.

The financial statements should provide a good beginning in the study of operations. One should analyse these statements to see what they show daily, weekly, or monthly. Consider the following points. Does the performance of operations compare favourably with the operating costs? Do operating costs compare favourably with the budget, if not, where are they out of line? The budget is planned according to anticipated income, thus control should be related to income. Operating cost figures will show where tighter control measures can be instituted.

Records require careful consideration. Are they as simple as possible and do they give adequate information? Mary DeGarmo Bryan[2] has suggested the following records and procedures for their use in order to ensure optimum food cost control.

1. Recipe standardization for content and size of portions.
2. Production orders for meal or day.
3. Requisitions based on recipes and production orders.
4. Daily food cost reports showing distribution of purchases.
5. Perpetual inventories of staples.
6. Physical inventories of stores.
7. Specifications for all foods.
8. Adequate personnel records and procedures.
9. Equipment records.
10. Usual records and procedures for cash control.

Wendell G. Morgan[3] has emphasized that there are at least four essential points to consider in achieving an effective cost control system.

(a) "The cost of the system or its execution must be considerably less than the savings effected . . ."

(b) "The regular routine of the kitchen must not be hampered by the system procedures . . ."

(c) "The accounts in the institutional business office should control the cost of the college food service . . ."

(d) "The information supplied by the system must be sufficiently detailed to provide a basis for corrective measures. Such inefficiencies as over-production, poor purchasing, waste in cooking or spoilage, and pilferage, should be revealed by an adequate system."

Mr. Morgan also stresses that the information should be rapidly gath-

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From an address presented at the New Brunswick Home Economics Convention held in Sussex, N.B., Sept., 1950.

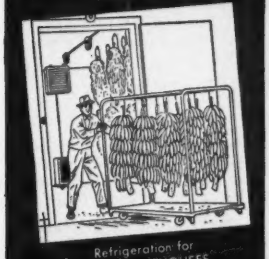
**References are to bibliography on page 48.*

OUR BUSINESS IS

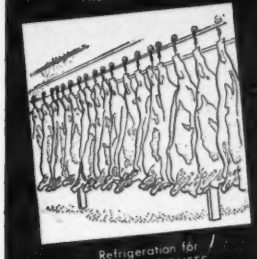
Keeping things

COLD

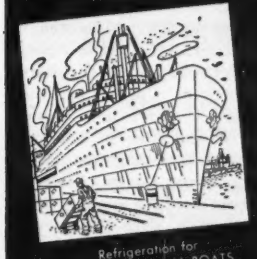
Refrigeration for FOOD STORES



Refrigeration for FRUIT WAREHOUSES



Refrigeration for PACKING HOUSES



Refrigeration for LAKE AND OCEAN BOATS

Refrigeration for FROZEN FOOD LOCKERS

Refrigeration for ICE CREAM AND DAIRY INDUSTRY

Refrigeration for HOTELS AND RESTAURANTS

Refrigeration for FUR STORAGE VAULTS

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ered and relayed to the supervisor so that remedial measures can be taken before serious loss is incurred. Finally, there is the important question: are all records kept up-to-date?

The next step is to study the plan of organization and see if it can be improved. Is there proper delegation of authority and assignment of responsibility, or is there overlapping of effort? Are the channels of communication downwards and upwards as clearly defined? An organization is only as strong as its weakest link. Can these links be made stronger by changes in the delegation of duties and the allocation of responsibilities in a more competent manner?

Over a period of years, there have been changes in food service operations. Margaret E. Terrell[4] suggests that these changes have come because of the greater emphasis on the value of desirable quality in food, the high cost of labour, and the size of the equipment investment. She goes on to point out that research in industrial management has shown that efficient procedures will provide maximum output at minimum cost.

Miss Terrell says that "The designing of an efficient layout is dependent upon: an appreciation of the qualities and characteristics of food materials; an understanding of the necessary functions of the food unit; the ability to plan for a logical flow of work which will make mass production possible under effective cost and quality controls".

With these points in mind, one should study the various units in the chain of operations to see if the layout can be planned to better advantage, without incurring undue expense. Then a better measure of control of all food and supplies in storage, and in the production and service sequence can be achieved. There will result an elimination of waste motions, a better co-ordination of materials, workers, and equipment; and thus labour costs will be kept in line.

In planning, effort should be made to provide good working conditions, with ease of supervision, and due allowance for future expansion or for any changes which may develop with regard to "fashions in food".

Whatever the type of layout, it should make provision for the best measures of control, so that there is a speedy flow of food and supplies with a minimum of time and effort. Flow charts showing the supply, production and service sequence, and the traffic flow will show where and how improvements can be made. When supplies and equipment are in suitable relationship to the work areas, and these areas are in consecutive order from the raw material through production to serving state, there will be less movement and saving in time and effort.

Special emphasis should be given to the service unit. Miss Terrell comments:

"It is imperative that the design for this unit allow for simple, logical procedures. Short distance for service, adequate equipment for holding food, convenient arrangement, freedom from obstructions and cross traffic in the path of workers, and arrangement for easy supervision, are features to seek in the layout for this unit".

A study of lighting conditions may lead to better quality in the food produced, since minimizing eye-strain will benefit personnel. An improvement in the sanitary conditions of the units will also result.

The space allowance required, equipment needs, and arrangement, will vary with the size and type of food service. The kind of menu will also effect the space allotted for food service.

Greater efficiency of operations and the enjoyment of better working conditions may result from checks on such items as the volume of steam pressure required; electricity, gas, and plumbing features; water supply; and temperature and humidity controls in the storage and production units. The amount and kind of labour-serving equipment required is also worth investigating.

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(To be concluded next month)

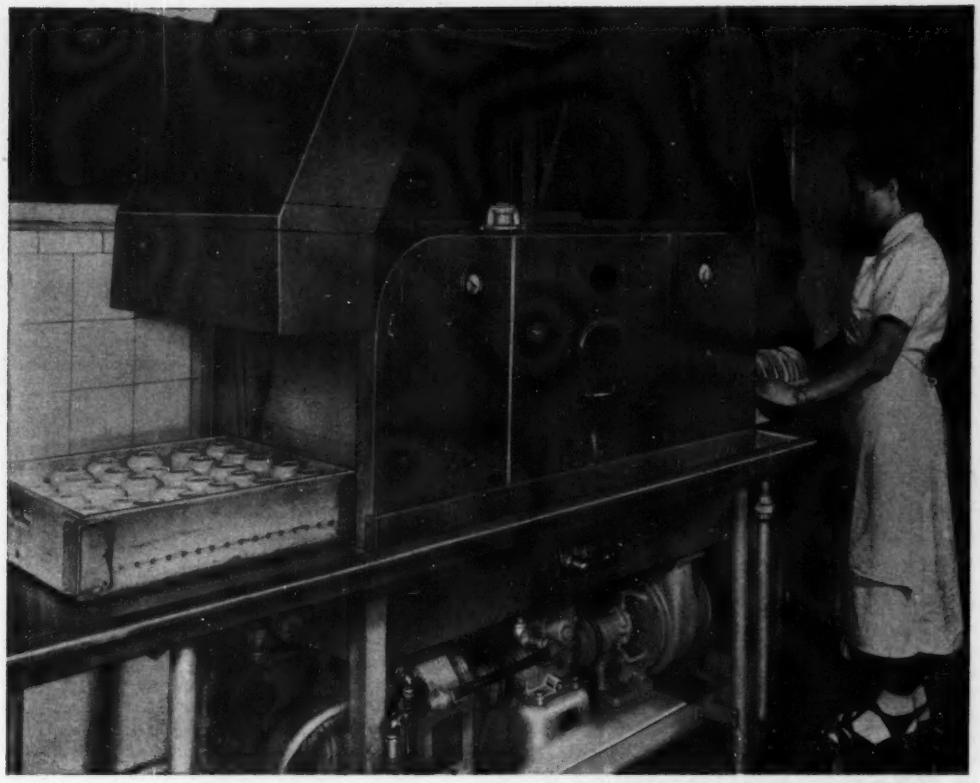
Charles T. Dolezal, M.D.

Charles T. Dolezal, M.D., assistant director of the American Hospital Association, died on Monday, March 19, at the age of 51. Doctor Dolezal had been assistant director and secretary of the Council on Professional Practice of the A.H.A. since May, 1948. He was well-known in Canada as a speaker at hospital meetings.

Memorial Chapel Dedicated to British Commonwealth Nurses

With simple but impressive ceremony, Her Majesty, Queen Elizabeth, opened the Nurses' Memorial Chapel in Westminster Abbey. This chapel has been dedicated as a memorial to the nurses of the British Commonwealth and Empire who gave their lives in World War II. It is believed to be the only memorial to nurses, midwives, and auxiliaries, in any national shrine. Located in the North Ambulatory of the Abbey, near the North Transcept, the chapel once formed the Upper Chapel of Abbot Islip's chantry. Islip became Abbot of Westminster in 1500 and when he died in 1532 he was buried there; the Upper Chapel, however, had not been used for worship since the Reformation, until this service of dedication.

The Abbey memorial is only one facet of the British Commonwealth and Empire War Memorial War Fund which was launched in 1946 by the *Nursing Mirror*, a British nursing journal. The Fund's second object is to provide post-graduate travelling scholarships for nurses and midwives of the British Commonwealth and Empire. The total which the fund hopes to achieve is £100,000 and so far approximately £77,000 has been received in gifts from all over the world.



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Evaluating Admission X-Ray Services

(From an address presented by Sister M. Veronica, Reg.N., Administrator of St. Joseph's Hospital, Saint John, N.B., at the Maritime Conference Catholic Hospital Association, Charlottetown, P.E.I., August, 1950.)

TODAY the number of hospitals throughout Canada doing routine chest x-rays on all admissions is growing daily. One reason for this is the fact that both federal and provincial governments have allocated grants for tuberculosis control, and routine x-ray on admission to the hospital is part of the survey. Since the installation of one of these units at St. Joseph's Hospital in April, 1949, we have received many enquiries regarding the set-up. Questions pertained to the location of the unit, the space required, the records kept, and the remuneration for the service. It is because of these questions that it was thought advisable to discuss these topics with the hope of giving information to others setting up an admission x-ray service.

Location

Location of the unit is the first factor. The logical place for this installation is near the admitting office. Since its use is for screening purposes only it is not necessary to have it in the main x-ray department. In our hospital, due to the lack of space, the unit was not placed in the office but close to the x-ray department where the films are taken by technicians. The chief disadvantage of this arrangement is that 24-hour service cannot be given.

The space required for a chest admission unit is 9 by 12 feet. However, we have been able to place it in a room 6 by 8¾ feet and the size of this room is adequate for all except a stretcher patient. It would be better if the room selected for this machine were large enough to allow a wheelchair, as many more patients can be x-rayed if they are not required to walk to the machine.

Record System

The record system is made as simple as possible. When the patient is in the admitting office the clerk makes out a small *white* slip requesting a routine chest x-ray and sends the patient to the x-ray department. If the department is closed the white slip is attached to the patient's chart to inform the nurses that the patient was not x-rayed. It is then the duty of the nurse in charge to see that the patient is brought to the x-ray department as soon as possible. When the patient has been x-rayed a *pink* slip, indicating that this has been done, is sent up with the patient to be placed on the chart.

Remuneration

Perhaps the most debatable point regarding this branch of hospital service is the question of remuneration. As stated previously this unit was provided by the government and there was to be no charge to the patient. When the unit was installed we were asked to do this work for 50 cents per patient for a period of one year, after which time accurate costs were to be determined and submitted to the government. Accordingly, a tentative report was prepared including materials used, salaries, rental of floor space, light, heat, and other details. This report showed that a charge of 68 cents per patient would be necessary to cover the cost of this service. As mentioned previously this report was only tentative as some of the costs had to be estimated. Since then we have engaged an accounting firm to make a cost analysis and give a detailed report which will be available at a later date.

Suggestions

From the above mentioned considerations the following suggestions are offered:

1. Place the admission x-ray unit near the admitting office.

2. Attempt to give a 24-hour service so that a greater percentage of patients will be x-rayed.

3. If possible, make a cost analysis to determine your actual costs.

Our experience with chest x-ray admission surveys has been gratifying, and, we feel, of real value to the community as well as being a great protection for hospital personnel. In one year nine positive cases have been discovered in our hospital, which otherwise might have been missed. Therefore, the installation of one of these admission units in every hospital is strongly recommended. ●

Colour Television to be Featured at Next C.M.A. Meeting

Officials of the Canadian Medical Association have concluded final arrangements for bringing to Montreal next June the nation's first medical colour television program. In commenting upon this, Dr. Norman H. Gosse of Halifax, President of the C.M.A., said: "We look upon colour television as a valuable new method in medical education. It has been added to our program not as an exhibition, although it is extremely dramatic, but because of its teaching value."

The Royal Victoria Hospital has offered its operating rooms as a transmitting point for the program. Colourcasts of the latest medical and surgical techniques will be beamed directly to special receivers set up in the Mount Royal Hotel, where the C.M.A. convention will take place.

Dr. Campbell Gardner, Chairman of the Association's television committee, explained the value of this new medium as a medical teaching aid. "Colour is essential," he commented, "because it gives a sense of third dimension, because it permits recognition of tissue and tissue changes, and because it permits anatomical orientation. Without colour, the most experienced surgeon would have difficulty in identifying an operation on a TV screen."

Smith, Kline, and French Inter-American Corp., Montreal pharmaceutical manufacturers, are pioneering the medium in Canada and have arranged the colour television program for the C.M.A.

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Ontario Institute for Hospital Administrators To Present Stimulating Program

Beginning the week of May 7th, the second Ontario Institute for hospital administrators will be held at Queen's University, Kingston. Following is a preview of the comprehensive program designed to cover many phases of administration.

May 7th

Organization and Operation

Organization and Function of Hospital Governing Body.
Responsibilities and Relationships of the Administrator.
Administrative Controls on Hospital Management.
The Administrative Conference.
Organization of the Hospital Medical Staff.
Control of Hospital Medical Practice.

May 8th

Personnel Problems

Hospital Personnel—Principles and Policies.
Practical Solution of Personnel Problems.
Centralizing the Personnel Function in the Hospital.
Field Trips to Kingston Hospitals in the afternoon.

May 9th

The Nursing Unit

Its function, planning, construction features, staff, equipment, and furnishings.
Planning and Operating the Central Supply Room.
Banquet in the evening.

May 10th

Admissions, Collections, Rates

Admitting procedure.
Credit Control and Collections.
Development of the Hospital Rate Structure.

Hazards and Medico-Legal Problems

Hospital Explosion and Fire Hazards.
Hazards Common to Patients and Staff.
Medico-Legal Aspects of Hospital Administration.
Hospital Insurance Protection.

May 11th

Purchasing and Stores Procedures

The Techniques of Hospital Purchasing.
The Physical and Staff Requirements of the Stores Department.
Control, Issue, and Inventory, of Stores and Equipment.
Hospital Cost Accounting.
Preparation of the Budget.

U. of T. Post-Graduate Course in Psychiatric Nursing

A course preparing graduate nurses for clinical supervision and teaching in psychiatric nursing is given each year at the School of Nursing, University of Toronto, with field work at Toronto Psychiatric Hospital, Toronto, Ont., and at other institutions. The group is part of a larger class which unites with nurses from other services such as, obstetrics, medical, operating room, et cetera. Each nurse studies recent developments in her own field, but brings to the attention of the whole class the value of her individual training and point of view, thus enriching the entire class by her experiences.

Recent trends in nursing are studied in the light of world needs and developments. The whole course is rounded out by field work which is arranged individually for students according to their needs and the available fields. The course is taught in co-operation with the staff of Toronto Psychiatric Hospital and makes use of its resources in teaching material. Throughout the course emphasis is placed on the sound nursing care of patients and students are imbued with an individual approach to the human problems of patients. Conferences on all subjects are open to the students in order that they may hear the views of the various members of the psychiatric team and contribute their own. Students are afforded the opportunity to see and nurse patients who are given the modern, up-to-date treatments and investigations used in psychiatric work today, such as insulin, leucotomy, electroencephalography, et cetera.

The psychiatric hospitals in Toronto are developing medical and nursing teaching, so that, in addition to their own studies, graduate-nurse students observe and participate in the program for undergraduate student nurses affiliating in psychiatric nursing. The discipline of explaining concepts to young and eager student nurses is a valuable part of the course.

The mental health aspect of all supervision and nursing is rapidly increasing in importance and, with strong backing from federal funds, money is available to train personnel. The aim of this course is to supply the training so that nurses will be ready not only for mental hospital work, but in all fields. The demand for nurses with this training is, as always, greater than the supply. General hospitals are being urged to open psychiatric units but experienced nurses to staff such units cannot be prepared in a day.

Further information pertaining to this course can be obtained from the Secretary, School of Nursing, University of Toronto, Toronto, Ont.

—O.F.G.

New University Course in Hospital Administration

The University of British Columbia recently approved a course in commerce and hospital administration which will be added to the curriculum next year. At the end of five and one-half years' training, students will receive a bachelor of commerce degree and a diploma in hospital administration.

The course is to be given jointly by the university and Vancouver General Hospital. It will include basic courses in commerce, nursing, social work, and home economics. Students must spend at least one summer in hospital employment before entering the third year of the course. At the end of that year there is a four-month internship at the Vancouver General Hospital, then another year at the university. The final 17 months of the course will be spent in internship.

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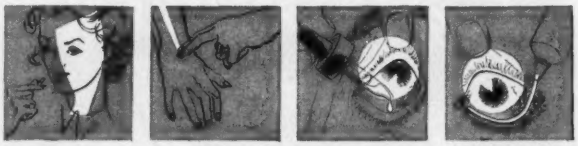

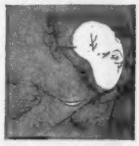

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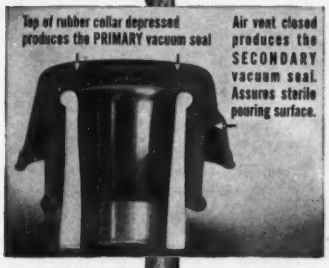

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Notes About People

A. J. Swanson Appointed Secretary-Treasurer of O.H.A.

The Board of Directors of the Ontario Hospital Association have announced the appointment of Arthur J. Swanson, Superintendent of the Toronto Western Hospital, as Executive Secretary-Treasurer. He succeeds the late Dr. Fred W. Routley.

Mr. Swanson has been active in hospital work for the past quarter century. He is a past president of the O.H.A. and has been a member of its Board of Directors almost since the inception of the organization. He is a zealous participant in all of the Association's services and is also well known in the hospital field from coast to coast. For two successive terms, he served as president of the Canadian Hospital Council and continues as an *ex officio* member of its executive committee.

* * * *

Leonard Goudy Appointed to U.S.A. Public Health Service

Leonard Goudy, secretary of the American Hospital Association's Council on Administrative Practice, was recently appointed consultant on hospital civilian requirements to the new Civilian Health Requirements Division of the Public Health Service. In this capacity, Mr. Goudy will spend some time in Washington, D.C. The newly formed Division of Civilian Health Requirements will handle all priorities, allocations of critical materials, and other activities related to hospital and health needs.

* * * *

A.H.A. Appoints Director of Professional Relations

Dr. Malcolm T. MacEachern, who last year retired as director of the American College of Surgeons, has been appointed director of professional relations of the American Hospital Association and assumed his new post on March 1st. In his new position Dr. MacEachern will be concerned with the Association's programs which are aimed at developing better professional relations in hospitals. Dr. MacEachern is a past president of the Association and received its award of merit in 1941. He is also director of the course in hospital administration at Northwestern University, Chicago, Ill., and will continue this affiliation.

* * * *

WHO Director-General Honoured

Dr. Brock Chisholm, director general of the World Health Organization, was honoured recently by the University of Nancy, France, when the degree of Doctor Honoris Causa of the University and of the Medical Faculty was conferred upon him.

* * * *

Ernest Gagnon Retires

Ernest Gagnon has retired from his position as business manager at St. Boniface Hospital, St. Boniface, Man. Mr. Gagnon has been on the hospital staff for 40 years and has also engaged in many community affairs. Last fall, when he retired as secretary of the Manitoba Hospital Association, a position which he held for many years, Mr. Gagnon was awarded an honorary life membership. Although retired, he plans an active future, hopes to set up an insurance brokerage, and golf.

Ernest Gagnon.

Superintendent Appointed to Civic Hospital, North Bay, Ont.

Brock Payne of Niagara Falls, Ont., has been appointed superintendent of the new Civic Hospital at North Bay, Ont., and assumed his duties at the beginning of March. Mr. Payne has had wide and varied experience in military and civilian hospitals. From 1942 to 1946, he served with the Corps of Military Staff Clerks of the Canadian Army at the Military Hospital in London, Ont. In 1947, Mr. Payne joined the staff of the Greater Niagara General Hospital at Niagara Falls, as assistant superintendent, a position which he held until his resignation a few months ago.

* * * *

Advisory Appointments Announced by D.V.A. Treatment Services

Two doctors have been appointed to advisory posts to the Director General of Treatment Services, Department of Veterans Affairs. Dr. Wallace Wilson, western regional medical officer for D.V.A., has been appointed adviser in geriatrics to the Director General. Dr. Wilson will still act as consultant on all problems in treatment services in the western region. Dr. A. N. Zinovieff, director of the division of physical and occupational therapy of the Faculty of Medicine at the University of Toronto and consultant in physical medicine at Sunnybrooke Hospital, Toronto, has accepted the post of adviser in physical medicine to the Director General. He replaces Dr. T. H. Coffey who resigned this position last December.

* * * *

New Nursing Appointment at Greater Niagara General Hospital

Mrs. Jessie Porteous has been appointed associate director of nursing at the Greater Niagara General Hospital, Niagara Falls, Ont. Prior to her recent appointment she was director of nursing and principal of the School of Nursing for the Saskatoon City Hospital at Saskatoon, Sask. Mrs. Porteous holds a Bachelor's Degree in Nursing and also a teaching certificate. During the second World War, she was in charge of the R.C.A.F. Nursing Service for Canada.

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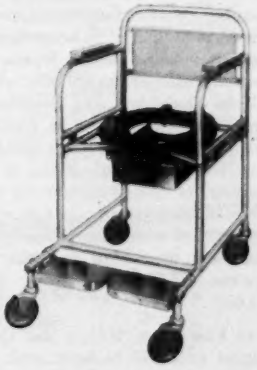

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Notes on Federal Grants

Construction

In Saskatchewan, federal grants will aid four hospitals. The Melfort Union Hospital is adding 37 beds to its present accommodation and will receive $37,000. The new section will include x-ray and laboratory facilities, a 22-bassinet nursery, major and minor operating rooms and ancillary services. At Kyle, a small hospital is being built which will have eight beds, x-ray, medical and surgical services. The grant is $5,000. A new 6-bed hospital is being constructed at Lanigan with federal and provincial governments each contributing $3,000. The new Birch Hills Memorial Union Hospital will have x-ray, medical and surgical services, and accommodation for 15 patients. It has been allotted $15,000 in federal funds.

Hospitals in Ontario have been granted $218,000 in federal funds recently. In Barrie, the patient accommodation of the Royal Victoria Hospital is being more than doubled by the addition of 36 beds, and 34 bassinets. Related medical, surgical, and obstetrical services are also being provided. The federal and provincial governments are each contributing more than $97,300. At Mountain Sanatorium, Hamilton, a new 64-bed building, to accommodate children, is being built to replace the present preventorium building which will be abandoned and demolished when the new building is finished. The federal grant will be $96,000. The Willett Hospital, Paris, is increasing its accommodation by providing 22 more beds, an 8-bassinet nursery, and additional medical, surgical, and obstetrical facilities. It receives a grant of more than $24,600.

At Blue River, B.C., a Red Cross outpost unit will be built with the aid of a federal grant. It will consist of a 3-bed unit to provide emergency hospitalization, home nursing care, out-patient and public health nursing services for about 500 people in the district.

Mental Health

As further steps in improving mental health services in Saskatchewan, the federal government has allotted funds to equip a research laboratory in the Munroe Wing of the Regina General Hospital, and to enlarge the x-ray facilities in the Saskatchewan Hospital, Weyburn. During the past year, a doctor trained in biochemistry has been employed in the Munroe Wing to organize a research program involving biological, sociological, and psychiatric problems of patients with various types of mental illness. Installation of laboratory equipment will enable this work to be extended. Portable x-ray equipment will be purchased for the Saskatchewan Hospital in Weyburn. It will be used for orthopædic work, thus eliminating the need for transporting patients to and from Regina for this special service. Cost of the laboratory and x-ray equipment is estimated at $9,100.

To increase the range of treatment available to mental patients in Manitoba, a new type of electrostimulator is to be obtained. This machine has been extensively tested in the United States where it has been found to be particularly useful in treating certain aged patients.

Use of federal funds has been authorized to obtain the part-time services of staff members of the University of New Brunswick, Fredericton, as consultants in various phases of the province's developing mental health program. The advisers will be called upon when needed to give lectures and prepare information on various aspects of mental health.

An analysis of the long-term costs of public and private mental health services in Canada and of the advantages of certain forms of treatment and service is being undertaken at the University of Toronto, Toronto, Ont. The study, expected to take about three years to complete, is being financed by federal grants.

The first phase of the project involves a study of the historical background of mental health policies in Canada to determine trends in legislation, administrative organization, cost and development of hospitals, homes, clinics, et cetera. The second part will be a detailed analysis of the cost of mental health services in recent years. To cover both public and private services, it will be designed to bring out trends in expenditure, per capita costs of care in institutions and other places. The third phase will attempt to evaluate in dollars and cents those parts of the mental health program which stress prevention of illness and rehabilitation. The research is under the general supervision of Dr. H. M. Cassidy, Director of the School of Social Work.

Public Health

To help control communicable diseases among indigent patients in New Brunswick, a small grant has been authorized to pay for new antibiotics such as chloromycetin, and aureomycin. This is an extension of a service whereby the province, for some time, has provided certain vaccines, sera, and other biological products free of charge.

A bursary has been approved to enable a chemist with the provincial industrial hygiene laboratory, Winnipeg, to take a short course in the problem of poisonous water supplies. The course is given at the University of Michigan.

Research

Studies concerning diphtheria are being carried out by the University of Toronto's department of hygiene and preventive medicine. With the co-operation of the municipal departments of health at Toronto and Hamilton, several thousand cultures are being obtained from the noses and throats of school children when they receive their physical examinations. After being tested for diphtheria bacilli, positive and suspicious cultures will be submitted to the university for virulence testing and typing. On the basis of this information, the investigators will be able to determine the number of persons who are carriers. As the survey will take about two years to complete, it is expected that the data

(Concluded on page 68)

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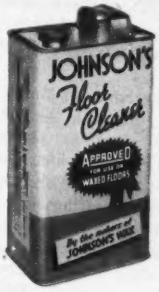

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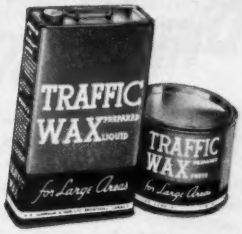

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◂ Health Care Plans ▸

Ontario Blue Cross Plan Celebrates Tenth Anniversary

An "Open House" was held on March 19th, at the Ontario Hospital Association building in Toronto, as part of the special ceremonies to celebrate the tenth anniversary of the Ontario Blue Cross Plan for Hospital Care. Among the guests of honour were the Lieutenant-Governor of Ontario, the Hon. Ray Lawson, Dr. Malcolm T. MacEachern of the American Hospital Association, and John R. Marshall, president of the O.H.A., as well as representatives of the provincial and municipal governments. Mr. Marshall made the presentation of parchments to the first ten groups to enroll in the Plan. A layette was also presented to Laurier Villeneuve of Cornwall, who is the father of the first baby born on March 17th in Ontario to parents enrolled in the Plan.

A highlight of the ceremonies was the presentation of gold service pins, bearing the crests of the O.H.A. and the Blue Cross Plan, to the men who initiated the Blue Cross movement in Ontario. The recipients were A. J. Swanson, superintendent of the Toronto Western Hospital; R. Fraser Armstrong, superintendent of the Kingston General Hospital, Kingston, Ontario; and Harvey Agnew, M.D., formerly executive-secretary of the Canadian Hospital Council.

* * * *

Hospital Insurance Premiums Increased in British Columbia

A bill passed recently in the B.C. legislature provides for an increase in compulsory hospital insurance premiums. Effective March 15th, the premiums have been raised from $33 to $42 yearly for families and from $24 to $33 for single persons. In addition, patients will pay $2 to $3.50 a day for the first 10 days in hospital—a payment which previously was included in the premiums.

John R. Marshall, president of the Ontario Hospital Association, presents parchment to A. G. Stewart, manager of Cunard Donaldson Ltd., at the special tenth anniversary ceremonies on March 19. This company joined the Blue Cross Plan on March 17, 1941, and was the first group enrolled.

Alberta Blue Cross Extends Subscribers Benefits

The Alberta Blue Cross Plan has announced an extension of benefits to its subscribers which became effective on March 1st. Subscribers are now entitled to 120 days of hospital care and treatment on admission to a member hospital as a bed patient. Previously patients were entitled to only 30 days care and treatment. Subscribers will also receive full compensation when hospitalized outside their home area in a Blue Cross hospital anywhere in Canada, the United States, or Puerto Rico, and will be entitled to the same benefits they would receive in their home area. This arrangement, known as the Inter-Plan Service Benefit Bank, became effective on January 1, 1951.

Also effective as of March 1, there will be no limit on the Plan's payment for x-ray or physiotherapy treatments, on which maximum charges of $35 and $30, respectively, were formerly attached. The new extension of time means a 120-day period of continuous care, and is applicable each time a subscriber is admitted to hospital. Payments to non-Blue Cross hospitals remain at a maximum of $5.50 per day, but the contract limit has been extended to 120 days also.

There are now approximately 120,000 Blue Cross subscribers in Alberta. The present cost for groups is $1.30 a month for single persons, and $2.70 for family subscribers.

* * * *

Ontario Blue Cross Plan Now Has Wings

By joining the Blue Cross Commission's Inter-Plan Service Benefit Bank, which became effective on January 1st, 1951, the Ontario Blue Cross Plan made its subscribers' certificates acceptable in about 5,000 participating hospitals throughout Canada and the United States.

* * * *

Peak Month for M.H.S.A.

The Manitoba Hospital Service Association has announced that the month of January was one of the peak months in its history. Over $200,000 was distributed to hospitals in payment of accounts incurred by 4,234 patients.


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RESILIENT LINOLEUM
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Provincial Notes

British Columbia

PORT ALBERNI. Voters recently approved a money-by-law for the construction of a new West Coast General Hospital. Present plans call for a five-storey, 102-bed structure to be built on a site adjacent to the present 40-year-old hospital, which it will replace. Cost of the new building is estimated at approximately $983,400.

* * * *

VICTORIA. A request for approximately $180,000 from the city council has been made by the Victoria Nursing Home for the construction of a $500,000 addition. Present plans call for a 100-bed extension to the existing 41-bed home. One-third of the construction costs will be provided by the provincial government and the federal government will contribute on a basis of $1,500 per bed or $150,000.

* * * *

VICTORIA. The new $350,000 addition to the Veterans' Hospital is expected to be ready for occupancy by the end of the year. The 64-bed structure will house older veterans, mostly ambulatory cases, who cannot provide for themselves. Patients will be fed from the main kitchen of the present 225-bed active treatment hospital and heating will be supplied from the existing facilities. Special features of the unit will be a large meeting room with a fireplace and sunrooms.

Alberta

VEGREVILLE. The new extension to the Vegreville Municipal Hospital is scheduled to be completed this spring. Last fall, the brick work and the new roof were finished and the interior work is now under way. Much-needed x-ray rooms, wards, and lounges will be provided with space in the new extension, cost of which is estimated at $100,000.

* * * *

FAIRVIEW. In February, the new wing of the Fairview Community Hospital was officially opened. With the new extension the hospital is expected to qualify as a 33-bed institution. The wing was completed at an approximate cost of $104,000 and extensive alterations were also made to the old part of the building.

Saskatchewan

BIRCH HILLS. At an official ceremony in February the new Birch Hills Memorial Union Hospital was opened. The two-storey structure was built at an approximate cost of $130,000 and contains a basement and a main floor. On the main floor are located the nine wards, and a three-room nursery, one of which is used as a suspect nursery, as well as the maternity and surgical departments, the examining room, x-ray room, and the doctor's office. The basement contains the nurses' and staff quarters, the kitchen, dining room, recreation room, laundry, and furnace room. The hospital, which was built as a memorial to soldiers of the district who died in World War I and II, will serve the village of Birch Hills and its rural municipality, as well as part of the municipalities of Invergordon and St. Louis.

Manitoba

WINNIPEG. Construction grants of $536,000 have been approved for the proposed $2,700,000 Children's Hospital. The money will be contributed by both the federal and provincial governments. Erection of the building is planned on a site near the Winnipeg General Hospital and it will be fully equipped as well as having a nurses' home, intern quarters, and facilities for the Junior Red Cross.

Ontario

BROCKVILLE. At the end of February the new wing of the Brockville General Hospital was officially opened. Built at a cost of more than $600,000, the four-storey addition contains 61 beds and increases the total bed capacity of the hospital to 175, including 23 bassinets. The "T"-shaped structure is located immediately south of the old hospital and is joined to it. The main kitchen, with its auxiliary services, and the nurses' and employees' dining room, are located in the basement. Space has also been allotted here for the future installation of a new x-ray department. The administrative section is on the main or first floor, as well as private and semi-private rooms. A special feature of the second floor is the children's department, while the maternity section is on the third floor.

* * * *

FOREST. Permission to raise funds for the erection of the North Lambton Hospital has been granted by the provincial government and a campaign will be launched shortly to raise $200,000 for the proposed building.

* * * *

HAMILTON. The newly finished x-ray and radium therapy wing at the Hamilton General Hospital was opened for public viewing last month. Built and furnished from funds provided by the Ontario Cancer Treatment and Research Foundation, the wing contains such equipment as a Keleket 400,000 supervoltage x-ray unit and another machine of lower voltage. Construction and equipment costs are estimated at $200,000.

* * * *

SAULT STE. MARIE. A new floor containing 19 beds was opened recently at the Plummer Memorial Hospital and the increased accommodation consists of five private rooms, three semi-private rooms,

and a five-bed ward. The total cost of the extension is estimated at $130,000.

* * * *

TRENTON. At a recent formal ceremony the Trenton Memorial Hospital was officially opened. This building, dedicated to the memory of district servicemen who died in World War II, contains 74 beds and 17 bassinets and was built at an approximate cost of $550,000.

* * * *

WINDSOR. Many new projects are being planned by Grace Hospital this year. About $2,000 will be expended on maintenance services and improvements to the existing buildings, as well as the installation of air conditioning in one of the operating rooms. Following these improvements the hospital plans to construct a new heating plant at an approximate cost of $100,000 and a nurses' residence at a cost of about $450,000.

* * * *

WINDSOR. Tenders were called last month for the construction of a 176-bed wing to the Metropolitan General Hospital. Building is expected to get under way this year. The five-storey structure, to run north and south, will be attached to the existing hospital. A larger neoplastic clinic for the treatment of cancer patients will be located in the basement and the first, second, and third floors will be used for adult patient accommodation. The top floor will be given over to the children's department.

* * * *

Quebec

MONTREAL. The Royal Victoria Hospital will launch a campaign this spring to raise $7,000,000 with the objective of modernizing and expanding present facilities. Approximately 277 beds will be added when the project is completed. Included in the present plans will be the construction of a new nine-storey unit on property behind the main building. It will contain operating rooms, three floors for semi-private and public wards, and, in addition, many other facilities such as laboratories, kitchens, et cetera. Parts of the main building will be rebuilt and modernized. The present public wards will be made over and the out-patients' department will be provided with additional facilities. Better teaching accommodation will also be included.

* * * *

MONTREAL. It is expected that construction will begin this year on a new nurses' residence at the Montreal Convalescent Hospital. Present plans call for a three-storey structure to be completed this fall. Funds to assist in this construction and for an extension of the fifth floor of the hospital were raised during the joint Hospital Campaign for funds last year.

* * * *

SHERBROOKE. Construction of the new Sherbrooke Hospital is progressing rapidly and it is expected that the building will be ready for occupancy sometime in May. Patients and staff will then be transferred from the present hospital in East Sherbrooke. The five-storey structure will contain 139 beds and 25 bassinets. The ambulance entrance, out-patients' clinic, dental clinic, kitchens, and staff cafeteria, will be located on the ground floor, while the main entrance, the administrative section, and the technical services will be on the first floor. Public wards and the children's department will occupy the second floor and space is provided on the third floor for the surgical department, which will contain two major and one minor operating room. The maternity section is on the fourth floor.

Newfoundland

ST. JOHNS. The Merchant Navy Hospital which was operated by the government during the first and second world wars was closed in February. However, it will continue in vital hospital work by providing a home for nurses at the St. Johns General Hospital and space for classroom training. After the first World War the building became a private hospital until the outbreak of the second World War when it was again taken over by the government as a merchant navy hospital.

Volunteer Aid in a Mental Hospital

Volunteer recreation work among patients at the Hospital for Mental Diseases, Selkirk, Manitoba, has been given more community support. Formerly carried on by four volunteers under the leadership of Mrs. Walter H. Rice of near-by Winnipeg, the project will now have the assistance of an advisory board whose members represent various organizations throughout the city. The board will publicize the work being done and solicit aid from service clubs. As a first step, the board has decided to set up four committees to study ways and means, education, public relations, and transportation.

Dr. Edward Johnson, superintendent of the hospital, is in favour of more volunteers working in the wards. These persons will be screened and trained to make sure that they have the right attitude towards mental illness. There is a variety of projects for them to sponsor—teaching square dancing and ball room steps, organizing parlour games, sing songs, and arts and crafts classes, as well as providing prizes for bingo games. For every person working inside the hospital, several more will be needed to help with outside activities such as providing materials, supplies, and transportation to and from the hospital, and helping to raise funds.

The long-range objective of volunteer work is to make mental illness accepted as a form of sickness. Volunteers would help the patients by removing the feeling that they were outcasts and also help to dispel public ignorance about mental disease, as well as giving valuable assistance to the hospital staff.

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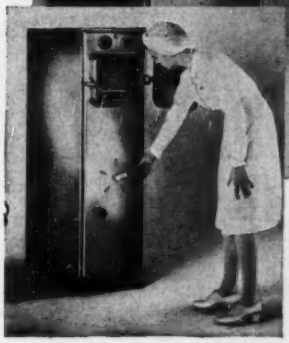

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With the Auxiliaries

B.C. Association Welcomes Four New Members

The British Columbia Association of Hospital Auxiliaries recently welcomed four new members: Junior Auxiliary to the Chilliwack General Hospital, Chilliwack; Women's Auxiliary to the Queen Alexandra Solarium, Mill Bay; Women's Auxiliary to St. Eugene's Hospital, Cranbrooke; and Women's Auxiliary to Creston Valley Hospital, Creston.

The junior auxiliary at Chilliwack reported the purchase of an aspirator, weighing scales, and an electric clock for the nursery. They also presented a silver spoon to each of the three babies born in the hospital on Christmas Day, and they are planning to buy a daylight lamp, as well as toys for the nursery.

Another new member, the women's auxiliary to the Queen Alexandra Solarium, Mill Bay, specializes in sewing for the little patients at the Solarium.

The Cranbrooke ladies' auxiliary are endeavouring to raise funds to completely furnish a room on the men's floor at the hospital. Last year they donated four all-purpose beds and two inhalation kettles to the hospital, as well as sewing 500 articles.

Activities of Other Auxiliaries

A net profit of $354.99 was received by the women's auxiliary to the West Coast General Hospital at Port Alberni, as proceeds from their "auxiliary shop". Members hope to raise sufficient funds to furnish two memorial wards for the proposed new hospital and have already purchased two wheel chairs as a start on the new equipment.

The Ladies' Aid to the Princeton General Hospital at Princeton recently presented a collapsible chair to the hospital.

The women's auxiliary to the Quesnel General Hospital have reported that approximately $729.60 was raised at a dance last fall. This dance was held in connection with a cattle sale which was held in the community at that time. The approximate membership in the auxiliary is 26.

* * * *

"Big Business" Year for Ladies' Aid at Windsor, Ont.

Last year was a year of "big business" for the Ladies' Aid to the Metropolitan General Hospital at Windsor, Ont. Total receipts for the year were $15,770.34, with disbursements of $10,425.34, all of which was used for the benefit of the hospital. The annual Country Fair was the main money-raising affair of the year and this netted approximately $6,516.72. Money was also raised through the sale of old dining room furniture, a rummage sale, and membership fees.

Some of the purchases made for the hospital by the auxiliary include a large oxygen tent, a smaller oxygen tent, equipment for a women's bathroom and a men's bathroom on the second floor, furnishings for the nurses' dining room, venetian blinds and drapes for hospital rooms, a food conveyor, a blood pressure machine, renovation of the first floor bathrooms, three bathroom chairs, and a coffee urn for the nurses' residence. In addition, the group provided $500 for a scholarship. This auxiliary has an approximate membership of 205.

* * * *

"Linen Week" Featured by Ladies' Aid at Yarmouth, N.S.

A "Linen Week" will be held by the Ladies' Aid to the Yarmouth General Hospital during the first week of May. The purpose of this week is to collect contributions, throughout the county, of linens and cottons for the hospital. Previously a "Jam and Jelly Week" had proved very successful and donations received were valued at approximately $500. Several fund-raising projects will be undertaken shortly as a means of raising money for the purchase of new x-ray equipment. In connection with this fund a parcel post sale will be held in May.

Auxiliary to Help Furnish Rooms in Nurses' Residence

Supplying furnishings for the new wing of the nurses' residence will be the main undertaking for the year of the women's auxiliary to the Saskatoon City Hospital, Saskatoon, Sask. The many services by which the auxiliary aids the hospital include providing comforts and treats for indigent patients, conducting school and play-time activities in the children's ward, and making dressings for the hospital. Last year a successful tag day, rummage sale, and "mum show" enabled the auxiliary financially to carry on its work.

* * * *

Auxiliary Makes Articles for Hospital at Brantford, Ont.

More than 7,000 articles were sewn by members of the women's hospital aid to the Brantford General Hospital at Brantford, Ont., last year. In addition, other affiliated groups contributed approximately 2,422 articles to the auxiliary. Members also operated two tea rooms, one at the hospital and one at Winston Hall, the nurses' residence. The auxiliary provides the services of a mobile canteen, library, and gift cart for use in the hospital. At present this group is planning to renovate 50 rooms for graduate nurses at Winston Hall.

* * * *

Fire-Gutted Hospital Aided by Auxiliary at Sydney, N.S.

To aid in a rehabilitation program for St. Rita's Hospital at Sydney, N.S., which was recently gutted by fire, the Ladies' Aid have donated the sum of $2,000. Originally this amount was scheduled to be contributed toward building costs of the proposed new hospital. However, in view of present needs, it has been allocated to assist in the rehabilitation program.

* * * *

Calgary Aid Contributes to Crippled Children's Hospital

Recently, the Ladies' Aid to the Red Cross Crippled Children's Hospital at Calgary, Alta., presented the hospital with a gift of $6,000. The money will be used to cover the cost of furnishing two six-bed wards.

Correspondence

The Nurse as Adviser in Construction Planning

Dear Mr. Editor:

I am appalled in reading the article, "A Symposium — Co-operation is the Keynote in Planning and Construction" which appears in the February issue of your magazine, to find slight mention in the article of the need of consultation with those who actually carry out the program in the hospital, namely: the nursing staff.

It is true, as a graduate of the degree course at the University of British Columbia in the early thirties, that I specialized in the public health aspect of nursing. However, I do not believe that, in my position as public health nurse in three different sections of British Columbia, I really lost touch with, or interest in, the community hospital. My interest and experience in the hospital situation was greatly sharpened by two years' spent in Europe in the supervision of public health and hospital facilities for Displaced Persons camps. Since my return from Europe, two years were spent studying nursing education at Columbia University, specializing in personnel administration.

As a result of my experience and further study I would unhesitatingly suggest (and this with feeling!) that it is time the interested nursing group itself be approached in this matter of planning and constructing hospitals. Perhaps the greatest contribution from the working group of nurses in hospitals is in suggestions that could be used to further space-time conservation which in the long run leads to a much more telling use of the nurse's time. This, I think, is a point to be pursued, in view of the problem presented by the shortage of nurses. Perhaps in some hospitals the basis of this shortage does lie in the inadequacies of the *milieu* in which a nurse has to work. This letter of course stresses the nurse's point of view but I think the housekeeping services are also entitled to a hearing, at which time a good many sturdy and reliable points would be brought out in their pertinent suggestions for short cuts and labour-saving devices.

It would seem to me that it might prove very worth while for some interested group to offer a scholarship to a graduate nurse (male or female) for the study of hospital architecture. I think as a consultant he or she would prove invaluable. Perhaps this suggestion should be made to the Minister of Health and Welfare. I have long felt that there was a crying need for a nurse with this additional training. I again repeat that this field, properly dealt with, might be one means of alleviating the nurse shortage.

Yours sincerely,
"(Mrs.) Marion C. Pennington",
Assistant Director,
School of Nursing,
Dalhousie University,
Halifax, N.S.

● *Touché!* The "Symposium" would have been richer for a nursing consultant on functional layout of hospital wards and services. Unfortunately few, if any, nurses have had the time or opportunity to achieve these qualifications.

Mr. Barnes does emphasize that "Those sections of the building which vitally affect the nursing service should be carefully checked over with the superintendent of nursing and her assistants" *(page 88)*. This is a "must" that might have been put into italics.

It occurs to us, too, that we have seen few suggested layouts for better functional arrangements worked out by nurses or nurses' groups and we wonder if they should not assume a little more responsibility in this regard. No doubt we shall hear more on the subject.

Suggestions like yours are needed for there is much to be done. Thank you for your comments.—*Editor.*

Federal Grants

(Concluded from page 58)

will show whether there is any variation in the carrier rate in different seasons of the year and, hence, if there is any possibility of forecasting when a diphtheria outbreak may occur. The study will also show whether the carrier rate is fairly constant or whether it increases when active cases of the disease are more numerous. As Toronto and Hamilton have had long-term programs of immunization to stamp out diphtheria, the statistics will be compared with those from other centres which have not had such well developed preventive measures in order to find out if the carrier rate is affected by immunization. This project is being financed by federal grants for public health research and is being directed by Dr. Donald T. Fraser, professor of hygiene and preventive medicine at the University of Toronto.

Tuberculosis

At the Manitoba Sanatorium, Ninette, services are being improved by changing the King Edward Pavilion from a ward for ambulant patients to an observation-type pavilion where patients will be given modified bed care under regular nursing supervision. A federal grant will meet the salaries of three additional staff members and the cost of technical equipment for the pavilion.

Federal funds have also been earmarked to pay the fees of a skilled anæsthetist who comes from Winnipeg to Ninette when major surgery is undertaken. Formerly these fees were charged to the patient. Also, in accordance with the principle of extending free treatment for tuberculosis, a federal grant will meet the hospitalization costs of eight more patients who can now be accommodated at Ninette because of alterations in the infirmary building.

To help meet the building costs of the first unit of British Columbia's new tuberculosis hospital in Vancouver, the federal government has allotted $396,000. The unit will contain the administration section and 264 beds.

The federal government will assist the St. Francis Sanatorium, Sherbrooke, P.Q., to improve its x-ray equipment. The apparatus is located in the sanatorium's dispensary, adjacent to the Hotel Dieu Hospital. ●

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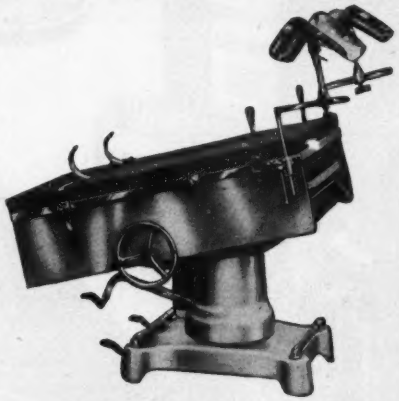

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Here and There

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R. Scott Stevenson,
M.D., F.R.C.S., Edin.
London, England.

WE who live in the age of antibiotics and sulfonamides, of fenestration, and electronics, of folic acid and stilbesterol, propylthiouracil, and isotopes, of cardiac surgery, and bronchoscopy, may perhaps be forgiven if we think we are living in the Golden Age of medicine. But as Winston Churchill said to the London College of Physicians a few years ago: "The longer you look back, the farther you can look forward". Throw your minds back a hundred years to that decade from 1846 to 1855, which the medical historian, Fielding Garrison, described as "the most brilliant in the whole history of medicine". For it was in this period that the laryngoscope was invented—a small thing indeed, but regarding which rival claims have given rise to so much discussion and controversy.

The Days of Medical Giants

Those were the days of such giants of experimental medicine as Claude Bernard, the greatest physiologist of France, who said: "Put off your imagination as you take off your overcoat when you enter the laboratory—but put it on again as you do your overcoat when you leave the laboratory". Carl Ludwig, professor of anatomy and physiology for nearly half a century at Marburg, Vienna, and Leipzig, lived at that time and was described by someone as "like one of the great architects of the Middle Ages who built the wonderful cathedrals which we all admire and whose name no man knows". At the same time, Louis Pasteur, at Lille, was working on the causes of fermentation; Lister, in Edinburgh, was publishing his first essay on inflammation; and Charles Darwin, in Kent, was writing "The Origin of Species". William Thomas Green Morton administered ether anaesthesia for a surgical operation at the Massachusetts General Hospital in 1846 and in 1847 James Young Simpson, introduced chloroform anaesthesia in Edinburgh. In the same year, Ignaz Semmelweis conquered puerperal fever by crude but undoubtedly antiseptic methods in his wards in Vienna.

Those were the days of Virchow, the founder of pathology, of Bright of Bright's disease, Addison of Addison's disease and pernicious anaemia. In 1851 Helmholtz, the great physiologist whose theory of hearing still holds, invented the ophthalmoscope and in the same year Pravaz invented the hypodermic syringe. Those were the days of James Marion Sims, the founder of modern gynaecology, and of Florence Nightingale—no dove but an eagle, as Lytton Strachy describes her—the autocratic reformer of nursing.

In 1848, a wave of unrest swept across Europe—that half-forgotten revolution from which some of the best elements in American life have sprung — a resurgence of the European revolution of 1789 that had been damned back by the imperialism of Napoleon. Among the refugees who followed King Louis Philippe from Paris to England was a professor of singing at the Conservatoire, Spanish by origin and Manuel Garcia by name. Garcia settled in London in 1848 as a teacher of singing and did not return to Paris for some years.

Experiments with a Mirror

One sunny afternoon in September, 1845, however, Manuel Garcia was on holiday in Paris and, strolling in the garden of the Palais Royal, observed the flashing of the sun on the window panes of the colonnaded quadrangle. Preoccupied with the problem of how to see the movements of the vocal chords, an idea which he had often repressed as quite unrealizable, he suddenly had a vision, as if actually present before his eyes, of one mirror reflected in another. He hurried off to a friend to ask the name of someone who could supply a suitable mirror. He was directed to Charriere, a well-known surgical instrument maker, who was able to sell him for six francs, a small dentist's mirror with a long handle that had been exhibited without success in London at the Great Exhibition of 1851. Impatient to try the experiment, Garcia ran to his hotel, obtained a hand mirror, warmed the dentist's mirror in hot water, carefully dried it and placed it against his uvula. Then, flashing a ray of sunlight upon its surface with the hand mirror, he was thrilled and overjoyed to see reflected in it the interior of the larynx and the vocal cords wide open, so fully exposed indeed, that he could see a portion of the trachea. When his excitement had somewhat subsided, he began to study what was passing before his eyes; and the way the vocal cords opened and shut and moved in the act of phonation filled him with wonder.

Garcia had already written on the physiology of the voice and what he had just seen was supremely interesting to him as a physiologic phenomenon. Therefore, he described it at considerable length, in a communication to the Royal Society of London in 1855. Those were different days, for I hesitate to think what sort of reception a communica-

(Continued on page 76)

From an article appearing in "The Pharos", of Alpha, Omega, Alpha, May, 1949. This was first presented as a William W. Root Lecture in June, 1948. (Sub-headings are ours. —Ed.)

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The Birth of Laryngology

(Continued from page 72)

tion on physiology from a singing teacher would receive today from our most august and eclectic scientific society to which only half a dozen practicing physicians and surgeons have been elected members. . . .

Other Early Pioneers

The idea of examining the larynx had been in the minds of many men long before Garcia's successful demonstration. Celsus in the Augustan Age was said to have used a dental mirror to examine the throat but the word *speculum*, a mirror, was confused with specillum, a probe. Levret, an eighteenth century French surgeon, was said to have used a polished steel plate to look down the throat but it was only a polished steel tongue depressor. Dr. Bozzini of Weimar in 1807 invented an instrument, for examining the throat, which consisted of a speculum divided with a vertical partition, so that there were in fact two canals and two mirrors. One mirror was intended to convey the light, the other to receive the image—an arrangement which we now know is quite unnecessary. But it is unlikely that Bozzini ever saw any part of the larynx with his speculum. Dr. Senn, of Geneva, published in 1827 an account of an attempt to see the upper part of the larynx with a mirror and suggested that it might assist in the diagnosis of certain cases of laryngeal phthisis. Dr. Benjamin Guy Babington is the most interesting of these early pioneers and some years ago I read a very persuasive article on Babington in the *Laryngoscope*, by Dr. Walter A. Wells, of Washington, D.C., setting forth the claim that Babington and not Garcia was the inventor of the laryngoscope. The claim must in the strict sense be allowed. Babington did indeed invent such an instrument and apparently used it on many patients, in conjunction with a hand mirror to reflect the light. But, alas, he had no disciples nor pupils; he recorded no cases; he never tried artificial light; and there is no evidence that he ever saw the movements of the vocal cords, although in his original description is written "the epiglottis and upper part of the larynx became visible in the mirror." . . .

After Babington and before Garcia, there were others who made the attempt to examine the larynx; Dr. Bennati of Paris, Baumes of Lyons, Robert Liston of London who used a dental mirror, Dr. Warden of Edinburgh who employed a prism, and Dr. Lavery of London who used a mirror at the end of a speculum and artificial light.

The Father of Laryngology

How was it, then, that Garcia rather than any of the others became recognized as the father of laryngology? First of all, Garcia, as a teacher of singing, had exercised his throat and so was able to hold the mirror in such a position that the vocal cords were seen. Secondly, in the scientific paper which he published, he laid emphasis not so much on the actual instrument but upon what he had observed in the larynx. His paper contains an admirable description of the action of the vocal cords during inspiration, expiration, and vocalization, as well as some important observations on the production of sound in the larynx. Thirdly, Garcia's paper gave rise to controversy —and controversy is an invaluable stimulus to the spread of knowledge.

In the summer of 1857, Professor Ludwig Turck of Vienna, who may have read in the Paris *Gazette Hebdomadaire de Médecine* some comments on Garcia's original paper, tried to use dental mirrors with the aid of sunlight to examine the larynx in the wards of the great General Hospital in Vienna. However, when autumn came, he put them aside as useless, saying that he was far from having any exaggerated hopes about the employment of the laryngeal mirror in practical medicine. In November, 1857, Professor Johann Czermak, of Budapest, borrowed Turck's mirrors for what he called "physiological purposes" and, with the aid of artificial light and a large perforated concave ophthalmoscopic mirror, achieved success with them in examining the larynx. He improved the mirrors by making them larger and doing away with an awkward hinge which they had originally. Czermak said afterwards, quite correctly, that but for his invention of the reflecting mirror "laryngoscopy would have been a dead-born child".

In March, 1858, Czermak read his first paper on laryngoscopy before the Academy of Sciences of Vienna —he got in first, for Turck's article was not published until April, 1858 —and it was Czermak who insisted on giving credit to Garcia for the invention of the instrument. A fortnight later Czermak demonstrated the laryngoscope at a medical meeting in Vienna. Turck, who was present, claimed priority as the first to use the mirror in diagnosis of disease, a fact which Czermak admitted. Turck, in 1866, wrote that he had used a mirror for examining the larynx before he had ever heard of Garcia and that may, indeed, be true. However, I had the curiosity to look up the earliest writing by Turck on the subject and found that he gave credit to his predecessors, both Liston and Garcia, though he insists on his own priority to Czermak.

Rivals

Turck and Czermak, with increasing jealousy and ill-feeling, gave rival demonstrations of laryngoscopy all over Europe, visiting Paris in 1860 and London in 1861. Czermak was fortunate in possessing a capacious pharynx, small tonsils, and uvula, and a wide laryngeal aperture—in fact, it would have been difficult to find a subject better suited for laryngoscopy—and he delighted and astonished medical audiences with his brilliant demonstrations. In his claims for priority, Turck went so far as to threaten Czermak with an action in the High Court of Vienna. A commission of the French Academy of Sciences was appointed to investigate their claims, but with Solomon-like judgment divided a money prize between them and awarded them both honourable mention.

The truth appears to be that while many doctors had made attempts with varying success to examine the larynx with a mirror or prism, it was Manuel Garcia, the Spanish singing teacher of London, who first achieved real success in actual examination of the larynx. Ludwig Turck of Vienna was the first to apply the laryngoscope to medicine

(Concluded on page 82)

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Hospitals and Public Health

(Concluded from page 29)

There are numerous problems that arise in the maternity departments of hospitals which are of equal concern to the health department in reducing morbidity and mortality rates. Health departments should be in a position to help hospitals in planning and developing protective procedures. It is logical to hold maternal and child health clinics in hospitals. It ensures continuity of care, easy transfer of records, and adequate post-partum follow-up care. Health departments can and should be informed of births before mother and child leave the hospital. In some places, arrangements have been made for the public health nurse to see the mother while she is still in hospital, thereby establishing the best possible conditions for adequate follow-up care. Hospitals can, and do, enlist the aid of health departments in preventing or stopping outbreaks of infant diarrhoea, breast abscesses, et cetera, and in developing comprehensive programs for the specialized care of premature infants. The health department can assist the hospital laboratories in procedures such as determination of the Rh factor and typing sera.

Environmental Sanitation

Many detailed areas of effective co-operation could be used in this field. We shall mention only a few. There is no reason why a hospital should not receive the benefit of regular routine inspections by trained sanitarians. The hospital kitchen, dining rooms, formula rooms, et cetera, are certainly entitled to the same amount of attention given to restaurants. Do you refer your plans for plumbing, sewage disposal, water supplies, and so on, to the public health engineer? Do you consult the health department veterinarian concerning the safety of your milk supply? Do you call on the sanitarian to help you solve problems of rodent or pest control?

Public Health Education

Hospitals provide a most effective environment in which to educate the public in health matters, although full advantage is not always taken of this opportunity. Casual exposure to health educational material displayed in waiting rooms is not effective enough. Public health must be personally and directly related not only to the patient and his illness but to his family and visitors as well. During convalescent periods, patients frequently have time on their hands which could be partly, at least, occupied with some educational procedure. There is definite need for greater emphasis on health education as a preventive device in the management of chronic diseases, such as heart conditions and cancer, which have real community health implications.

Records and Statistics

It has been my experience that often hospitals are no better than some private physicians in reporting notifiable diseases, *i.e.*, their reporting is notoriously incomplete. In this respect, health departments should make a real effort to help hospitals develop a systematic routine method of prompt reporting. Although it is the doctor's responsibility to complete birth and death certificates, hospital personnel can assist him to be prompt, thus speeding the compilation of vital statistics. A large proportion of the health problems of a community are reflected in hospital clinical records. All too frequently they are not used effectively by public health nurses, social workers, and others who are concerned with follow-up and home visits. Their value should be quite apparent but it requires the agreement and understanding of all concerned to make them readily available.

Administration

All of the preceding discussion implies that there is need for a much more closely linked administration than has been in effect in the past. The achievement of this closer relationship will not come about automatically, but will require careful and continued planning, with understanding effort by all concerned. It has been said that "administration is an art which, like marriage, can be better appreciated by consummation than discussion". If health departments and hospitals are housed together, this co-operative administration is of course much easier. In some places, a single administration for both has been appointed; however, there is need for further experimentation in this field. A closer co-ordination in the training of public health officers and hospital administrators is desirable to develop executives who have sufficient understanding of each others problems to solve them effectively. The fact that the university course for hospital administrators in Canada is given at the School of Hygiene is a very significant trend.

As Professor Winslow remarked a few years ago, "Health today means so much more than the temporary postponement of the day when one's name is inscribed on a death certificate." Only in recent years have we gained the concept that a healthy individual is a community asset and a sick individual, or a man who dies prematurely, is a community liability. The modern idea of complete medical care, as I mentioned earlier, is no longer an individual responsibility. At least three important groups are heavily concerned. They are the hospitals, the doctors, and public health facilities. Good health for all the people cannot be provided by any one of these alone, nor by all three together unless efficient working relationships can be established. The Commissioner of Hospitals of New York City has recently said: "With every advance of medicine and public health, the interests of the hospital administrator and the health officer encroach more and more upon one another. Neither can afford to ignore the other and delay too long the happy results that a close union of the two would achieve for the community." On reaching this goal, your hospital is accorded greater prestige as the community centre for all health and medical activities. It will and should become, in fact, the focal point of all life-giving and life-saving activities.

A.H.A. Annual Convention

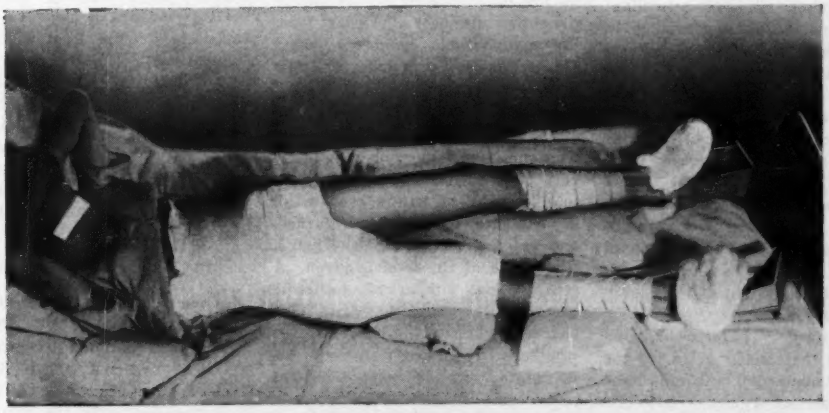
Plans are now under way for the 53rd Annual Convention of the American Hospital Association which will be held this year in St. Louis, Mo., from September 17-20. Headquarters hotels are the Jefferson, Lennox, Sheraton, Statler, and DeSoto. Room reservations are being accepted now by the Hotels Convention Reservation Bureau in St. Louis.

TUBERCULOUS RIGHT HIP

CASE HISTORY: D.S., female, age 22, had an early tuberculous arthritis of the right hip. It was necessary that she should be treated on an abduction or other type of frame. No sanatoria beds were available for six months and pending her transfer the hip traction in abduction was improvised as illustrated.

COMMENT: Immobilization in plaster of Paris alone was not sufficient. Elastoplast Extension Plaster was applied to both legs and tied to the bed-rail at the foot of the bed. Counter traction was obtained by raising the foot of the bed on blocks.

These details and illustration are of an actual case. T. J. Smith & Nephew Ltd., of Hull, England, manufacturers, publish this instance—typical of many in which their products have been used with success.



Elastoplast Extension Plasters are made from adhesive Elastoplast fabric with a CROSSWISE stretch. They provide the lengthwise rigidity essential for extension, whilst the sideways elasticity permits them to conform intimately to the varied contour of the limb. Available in width of 3" x 3 yd. lengths.

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Laryngology

(Concluded from page 76)

and to attempt to use it to diagnose diseases of the larynx. However, it was Johann Czermak of Budapest who developed the early instrument into a practical surgical tool of precision, popularized it with the medical profession and his pupils, and made it known throughout the world.

Only Six Francs

It is pleasant to be able to record that Manuel Garcia lived to be recognized as the "Father of Laryngology". On his one-hundredth birthday, in 1905, a brilliant international reception was held in the crowded hall of the Old Royal Medical and Chirugical Society in London. Delegates were present from universities, medical schools, colleges of music, and scientific societies all over the world. . . . Precisely at noon, Manuel Garcia was led to a crimson chair of state on a dias surrounded with magnificent bouquets which had been placed there by some of his musical admirers. He was wearing the insignia of the Royal Victorian Order, which King Edward VII had conferred upon him that morning. From the Spanish ambassador he received the Royal Order of Alphonso XII, and the representative of the German Emperor presented him with the Great Gold Medal for Science which had been given previously to only four scientists. Then Dr. Harman Smith, of the American Laryngological Society, presented Garcia with his portrait painted by John Singer Sargent.

It was a great day for the venerable singing teacher, a modest man of simple habits, who kept wondering what all the fuss was about. Originally, it was the controversies about falsetto and the registers of the human voice that had compelled him to want to see the actual movements of the vocal chords. The flashing of sunshine on the window panes of the Palais Royal had given him the key to his problems. But he was dumbfounded that this key should have unlocked for him the gates of royal palaces, a dozen universities, and innumerable learned societies. The applause and congratulations of the laryngologists of both hemispheres overwhelmed him. He had never meant to become the founder of a new medical specialty. After all, as he said himself, the mirror had only cost six francs!

Criticism and Reform

(Concluded from page 32)

daily in each department. This enabled us to determine the number of letters given out and to compare it with the number returned.

Summary

Since we have begun this system, we find an increasing enthusiasm in the entire nursing staff. Apart from the unfavourable comments, there are always quite a number of testimonies of appreciation and the staff looks forward to these.

The summary is presented somewhat briefly in the following manner. A tabulation is made of the total number of letters sent to all departments, the number returned, and the number answered. Then a percentage of the total is given. A separate but similar tabulation is made for the surgical ward. This summary permits the nurses to see whether their co-operation has helped to raise or lower the total percentage. By this, they may also determine the number of letters which were complimentary or critical of the service given in their department.

Further information in the summary gives the number of patients who were satisfied or who made no comment and the number of comments which are entirely satisfactory: enjoyed meals, appreciated sympathetic attitude of nurses, appreciated hearing daily prayers, names of particular staff members who have been mentioned for their efficiency, et cetera. Complaints, such as radios too loud, cold meals, insufficient attention to doctor's orders when the relief nurse takes over, slow admitting procedures, et cetera, conclude the summary.

Until recently, only the comments relating to each department were dispatched thereto. However, we have decided that it might create emulation if we sent the total summaries to every ward; henceforth, we shall put all of these tabulations on a large form so that comparisons can be made. Formerly, only the administrator and the director of nursing had access to them. The latter allowed her reports to remain in view of the student nurses on one or two occasions to see what the reaction would be. They enjoyed it and asked that such reports be sent to all departments, so we are confident that our plan will be acceptable to all.

Conclusion

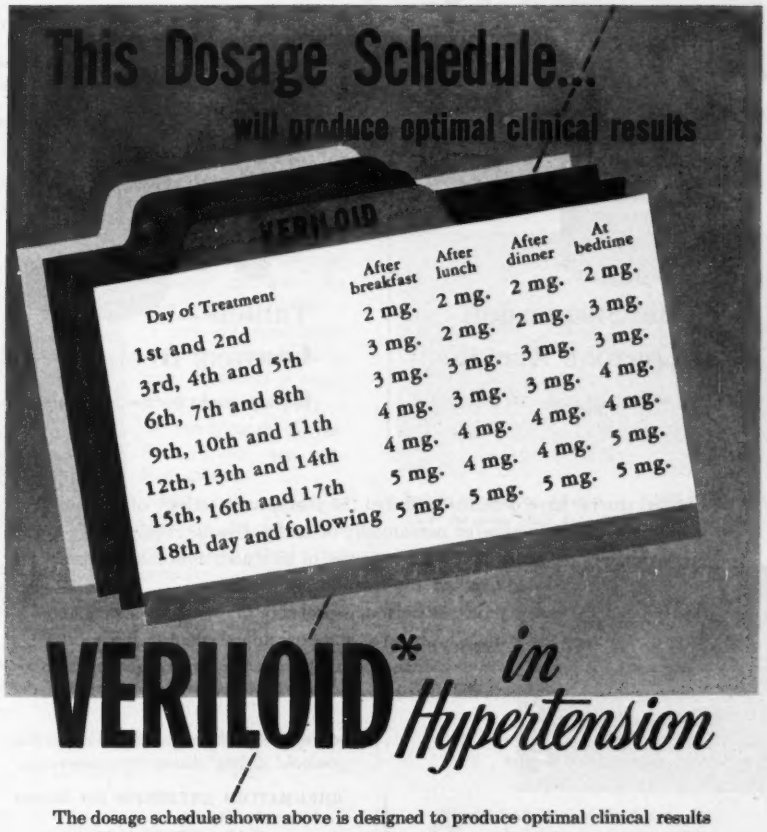
We have discovered that many causes for dissatisfaction among our patients hinge on details that can be readily adjusted. It is surprising how much their correction can do to create contentment among the patients. The comments which are brought to our attention by means of these "Friendly letters" have certainly been beneficial to the patients and to us. It is definitely an effective public relations tool and we like to believe that this system, as used in our hospital, is here to stay.

Congress on Physical Medicine to be Held in London, Eng.

The International Congress of Physical Medicine will be held in London, Eng., from July 14-19, 1952. In accordance with the regulations of the International Federation of Physical Medicine, the meetings of the congress will be reserved for matters dealing with the clinical, remedial, prophylactic, and educational aspects of physical medicine, and with the diagnostic and therapeutic methods employed in physical medicine and rehabilitation. Technical, scientific, and historical exhibitions also will be arranged. Applications for the provisional program should be addressed to the Honorary Secretary, International Congress of Physical Medicine (1952), 45 Lincoln's Inn Fields, London, W.C.2., Eng.

Erratum

In the February issue of *The Canadian Hospital* on page 70 is shown an aerial view of Regina General Hospital. Credit to architects who designed the new wing should have read: Van Egmond and Storey, in association with F. H. Portnall, Regina.



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Veriloid should be taken preferably with or immediately after meals and at bedtime, *but never more often than at 4-hour intervals.* Experience has shown that the average patient responds best to a *daily* dose of 10 to 12 mg. When an acceptable drop in pressure has been obtained without side effects, the dosage level at that point is considered the maintenance dose.

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Economy Corner

• *Swab Aids vs. the Old Fashioned*

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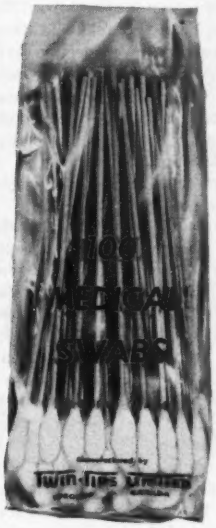

Besides wasting time, this task can prove expensive as well, for raw materials required to prepare applicators are extremely high in cost . . . almost as much as the price charged for ready-made Swab-Aids, which are uniform in size.

Just compare the following figures and you'll see that it's actually much more economical to use Swab-Aids:

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Cotton (Sufficient for 1000)	.30
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TOTAL COST	$3.20

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Cost per 1000	$2.00
Cost, in 10,000 lots, per M	$1.90
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It's pretty obvious from these figures that even by buying Swab-Aids the most expensive way . . . in 1000 lots . . . they're definitely a saving!

Uniformity of size, convenient shape, sanitary packing (100 to a cellophane bag), are other factors in favor of Swab-Aids. And, of course, the finest grade long-fibre absorbent cotton is used in their manufacture.

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The fact that Swab-Aids are packed in hundreds in cellophane makes it possible for hospitals to use only one bagful at a time . . . while the rest of the supply can be neatly packed away, clean and sanitary.

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Make your own comparison between hospital-made and machine-made swabs and we know you'll agree that machine-made Swab-Aids are far in the forefront both for superior quality and maximum economy.

When your hospital next needs a supply of swabs, order Swab-Aids from GILBERT SURGICAL SUPPLY CO., 471 BLOOR ST. W., TORONTO 4. You'll be glad you took our advice.

A Ten-Bed Hospital

(Continued from page 34)

has made the following statement in this regard: "It is not the policy of the Red Cross to permit a nurse to give an anaesthetic unless she has had special training in anaesthesia or unless it is in a true emergency".

The matron is responsible for the nursing staff and this does not always consist entirely of registered nurses—far from it. In some small hospitals, I believe, the greater part of the nursing staff is composed of less qualified persons.

The matron is responsible, too, for the domestic staff. I have mentioned already the case of a tempermental cook. There are also maids who may stay for one month or six months. There may be a laundress who can or who just cannot handle the electrical equipment, for you know it is not always as simple as a "turn of a switch". There may be a janitor or handyman who in all likelihood has never worked in a hospital before. There is *no* plumber or electrician. Hence the matron, if she can't turn plumber or electrician herself, must arrange to bring in these tradesmen when they are needed and costs mount every time she calls them.

In a 10-bed hospital there is no bookkeeper, cashier, or statistician. The matron must make up accounts. There are reports, monthly, quarterly, and yearly. Lucky is the matron who has had office training and who can type. But there are no adding machines. Some small hospitals have, as matron, a nurse just out of training and the training did not include a course in bookkeeping.

The matron is responsible for seeing that good, well-balanced, meals are served at low cost. There is no dietitian and no time to shop around for supplies. The board complains if costs run too high and, to combat this, perhaps the matron finds herself looking around for a cold-storage locker so she can buy a cow or pig. It is very seldom that the matron of a small hospital has taken a course in budgeting or stretching the hospital dollar, although it is amazing how some of them manage to do just that.

The matron must also keep things running smoothly and keep her staff from feeling frustrated and insecure. And she alone carries the burden, for in a 10-bed hospital there is no assistant matron.

Overwhelming Details

From what I have said, you can easily see that the problems of a matron of a 10-bed hospital are many. She has not just the worry of caring for sick people but also the overwhelming load of detail, all kinds of detail, from septic tanks to pumps that won't work, to reports that must be written. All this would wear down the strongest Florence Nightingale.

There is no temporary escape from this detail. The matron can't shut her door on it and forget it. She is always in the building, except on her day off,—if she ever has one. Her room is likely to be near the door of a sick room, below the case-room, or above the stoker. Peace and quiet are seldom hers. True, there may be times when there are not many patients in the hospital but even when the nursing load is not heavy the septic tank and the stoker and all her other troubles are present. Even if the nursing load is light, at times, she must always be ready to take in patients. She may have one patient in the morning and six by late afternoon. The hospital door must be open to those in need of care, whether or not the matron has her accounts up-to-date or if she has completed arrangements to have the plumbing repaired.

All this may appear to give the impression that matrons of small hospitals have more demands on their time than anyone else. On the other hand, I have an idea that in the minds of the people of the community, generally, there exists the erroneous belief that a matron in a small hospital has an easy time of it. After all, she has just a few patients to look after, say five or six, and surely a graduate nurse can do that? Therefore, it was to give you some insight into what it really means to take on the job of being a matron that I have gone into some detail.

Solutions for the Matron's Problems

However, it is useless to review these problems unless we can offer some suggestions about how the situation can be helped.

First of all, perhaps we could make better use of existing facilities. For example, we might write to the provincial Bureau of Hospitalization and arrange to have a building inspector visit the hospital. A member of the accounting department of the bureau would be glad to help the matron with general bookkeeping and accounting. The Public Health Engineering Department could help in problems that a nurse, as such, is not trained to solve. The Bureau of Food Control could likely be of assistance in connection with the hospital milk supply or the meat products, since local people cannot be expected to handle these problems. Another source of aid is your provincial hospital association. It can always be called upon for advice and assistance.

The community, too, can help the nurse in many ways. It can begin by taking a real, friendly, interest. Since the hospital exists to serve the community, let the people look upon it as *their* hospital. How? Well, for example, there are active Women's Hospital Aids, why can't there be a men's aid? The women mend sheets and have silver teas; therefore, why can't the men help, that is, aside from attending board meetings. The local municipal secretary-treasurer can help the matron a great deal. Perhaps one of the hospital board is a good furnace man and could drop in occasionally. Even if the matron could feel free to phone him, it would help immensely. The simple fact of knowing that she has someone to turn to is a tremendous boost to her morale. One way for the board and hospital staff to work together is to hold all meetings in the hospital and invite the matron to attend. Another good idea is to keep the community informed as to hospital progress and problems through the local newspaper. Again, it is a good idea to have a "hospital day" and invite everyone to see their hospital.

A final suggestion concerns hospital personnel. The development of doctor-nurse teamwork makes for efficient nursing care and for the smooth running of a hospital. I know one 8-bed hospital in Manitoba where such teamwork is a joy to behold. A little give and take can make all the difference in the world.

There is one problem on which I haven't touched. It concerns the

(Concluded on page 88)

A Ten-Bed Hospital

(Concluded from page 86)

supply of good matrons, of nurses trained for the job. Need I enlarge upon this very serious situation? I think that I have given you some indication of why there are not more qualified woman attracted to this work and also have given some hint as to what can be done about it.

May I ask for a better understanding on the part of hospital boards and communities in general, an understanding of the duties, responsibilities, and problems of the nurse administrator. In Manitoba, there are now eleven 8- to 10-bed hospitals in operation. Let us try to make them pleasant places for the sick and for the well.

Ivory Towers?

When the American Medical Association held its third annual medical public relations conference in Cleveland, Ohio, December, 1950, doctors heard certain criticism from both lay and medical speakers. Following are some of the comments:

"Doctors have an obligation beyond that of providing good medical care for their patients."

"Doctors are too aloof, and are unaware of the new currents of social thought."

"There's too much false dignity in the profession."

"We must consult more with lay people."

"Medicine's aloofness causes many troubles."

"We must learn to co-operate with lay groups and on public projects."

"Doctors have special privileges —they must also recognize that they have special obligations."

"Doctors regard discussion of medical subjects by the laity as unwarranted interference. That attitude is no longer valid."

"All too often doctors are accused of protecting the unscrupulous and incompetent in their ranks."

"We must take the people into our confidence and show that we have nothing to hide."

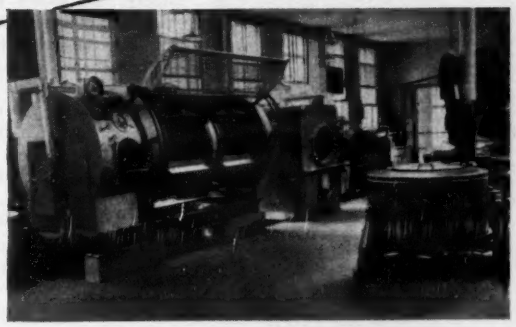
"Come down out of your ivory towers."

—Canadian Medical Association Journal, Feb., 1951.

PROVIDENCE, R. I.

Providence Lying-In

Another case where HOFFMAN complete laundry equipment service IMPROVED PRODUCTION *as planned!*



An elevated "Shell-Less" washer and an open-end "Shell-Less" washer increased linen capacity at Providence Lying-In, processing with less water and a greater speed. In the foreground is a 40" Hoffman "Open-Top" Extractor.

Better production was the goal sought by the Providence Lying-In Hospital, when it agreed to a complete Hoffman laundry survey and modernization plan several years ago.

At the time, the laundry operated 7 days a week, with overtime paid for Sundays. Primarily responsible for this costly practice was the fact that linen demands ran 70% above the rated capacity of the washers then in use!

Hoffman Laundry Engineers set about making a complete linen inventory and a cost analysis, and arranged for a classification and sorting system. This data led to recommendations for new equipment which Providence Lying-In installed in 1947.

Today, the linen requirements of this 185-bed and 185-bassinet maternity hospital are being processed with less handling and labor. Requisitions are filled faster and earlier, while the work week has been reduced to 5½ days.

The Plans for Your New or Modernized Laundry are Available Now—WRITE FOR SURVEY!

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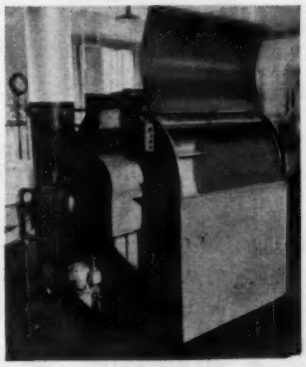

Rough dry work is handled in this Hoffman 36 x 48 "Economy" side-loading tumbler, in a balanced set-up matching the increased washer output.

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◄ Book Review ►

TERMINAL CARE FOR CANCER PATIENTS: A Survey of the Facilities and Services Available and Needed for the Terminal Care of Cancer Patients in the Chicago Area. A report published by The Central Service for the Chronically Ill of the Institute of Medicine of Chicago, Chicago, Ill., 1950 under the direction of Edna Nicholson, M.S. Pp. 211. Price, $1.25.

In this report valuable information has been assembled and analyzed regarding advanced cancer patients and the services and facilities required to care for them in a community. It shows the extent of existing provisions in the Chicago area and considers the steps which can and should be taken to provide additional services. The material outlines a basis for estimating the number of cancer patients requiring care, and the types, amounts, and cost of this care—information which could be applicable to advanced cancer patients anywhere.

Hospital care for such patients in Chicago is estimated at $5.00 per day for a minimum standard of care, $7.00 for average, and $15.00 for patients requiring maximum care, exclusive of the cost of physician's services, drugs, dressings, and incidental expenses. The actual operating costs in general hospitals in Chicago average approximately $14 to $18 per patient day.

The report discusses the various ways that home care can be provided such as through visiting nurse service. The problems of caring for the terminal patient in his home, however, are also clearly pointed out. It is stressed that communities can do much more to provide facilities for this type of care. As the cost of care increased, it was found that the number of families able to meet the cost decreased. Therefore the necessity of finding ways and means of financing adequate care has become more and more urgent.

Although this report deals with one specific disease, it contributes invaluable information to the general knowledge of the care of the chronically ill. Even more important, it provides a detailed blueprint of methods which can be used to guide any community in solving problems of this nature.

A.P.A.A. Art Salon to be Held During A.M.A. Convention

The American Physicians Art Association will hold its annual art exhibit during the A.M.A. convention at Atlantic City, June 11 to 15. Any doctor in the United States, Canada, and Hawaii may participate.

Over 200 trophies will be awarded to those submitting works of merit. Among these is the special Hesler Trophy, a large decorative cup depicting Yankee ingenuity, and a large Popularity Trophy which is given to the artist whose work receives the most votes during the convention. The annual art banquet will be held the evening of June 12th at the Marlborough-Blenheim Hotel.

J. Henry Hesler and Co., Inc., are the new sponsors of the association. Enquiries concerning the exhibit should be addressed to F. H. Redewill, M.D., Secretary, American Physicians Art Association, 760 Market Street, San Francisco 2, Cal.

To Read or Not to Read

In the main, there are two sorts of books; those that no one reads and those that no one ought to read. —*English Digest.*

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Canadian 2-Roll *STREAMLINE* Flatwork Ironer

for fine quality, low-cost ironing of all flatwork!

This ironer is designed for the medium sized hospital. It has the same built-in high quality of all Canadian ironers. The two roll return apron type ironer has frames and chests of Meehanite metal, highly polished, quiet gear drive, automatic safety guard and many other quality features. The CANADIAN TWO ROLL IRONER is fed from one side and endless ribbons return the work to the delivery table under the feed basket, which means that the machine can be placed close to a wall thereby saving floor space.

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ESTABLISHED 1902

An excellent ironer for the smaller hospital!

Devoirs et Responsabilités

(Continued from page 41)

celle qui réalise son objectif, c'est-à dire, la marche régulière vers le progrès où chaque pas en avant est consolidé au fur et à mesure.

Il faut viser au progrès. Pour le réaliser, il faut savoir faire face aux nombreux problèmes qui se présentent et les solutionner à temps.

Exécution des Directives

Du point de vue strictement exécutif, l'administrateur doit avoir la haute responsabilité du fonctionnement de tous les rouages administratifs, y compris le service des malades. Pour accomplir cette tâche, il est recommandé que l'administrateur organise ou finance ses propres activités, ce qui implique une délégation directe d'autorité et une organisation telle que les item les plus divers puissent être promptement portés à son attention.

Dans les grands hôpitaux, ou même dans ceux de grandeur moyenne, nous pouvons compter, au moins, une trentaine de services. Sans considérer les subdivisions, notons: le service des soins du malade, les internes, l'école d'infirmières, les laboratoires, la banque de sang, la radiologie, la physiothérapie, les archives médicales, les salles d'opérations, la salle de service centrale, les cliniques d'urgence, les cliniques externes, la comptabilité, le bureau d'admission, le département des achats, le service de santé des employés, le cuisine, la buanderie, le personnel domestique, et caetera. L'administrateur doit accepter la responsabilité de faire donner à ces services tout leur rendement. De plus, il doit s'assurer que chaque malade, tous, dans leur ensemble, soient traités avec bonté, suivant leur état.

Il ne doit cependant pas porter à lui seul la responsabilité entière et essayer de tout surveiller par lui-même, ce qui disperserait trop son attention et ne donnerait pas le rendement désiré. Et, même s'il a des chefs compétents dans chaque département, il ne peut trouver le temps voulu pour les item importants de l'administration générale, si tous sont directement sous son autorité.

Si l'hôpital est assez grand, l'administrateur doit avoir des assistants compétents; si la chose n'est pas possible, qu'il s'adjoigne, au moins, trois des chefs de département, de préférence, ceux de service général, et leur donne certaines responsabilités administratives, en plus de celle de leur propre département. Si ce mode est accepté, il faudra organiser des conférences quotidiennes, à heure fixe, pour ces officiers. Les autres chefs département pourront être invités, surtout s'ils en ont le temps, et être priés de le faire chaque fois qu'un problème de leur service doit être discuté.

Il est désirable que chaque hôpital ait en plus de sa charte constitutionnelle, une codification écrite des responsabilités administratives. Ces deux documents doivent répondre aux qualifications du personnel. Quelques personnes peuvent avoir plus de responsabilités que d'autres, mais du haut au bas de l'échelle, elles doivent être précises et bien déterminées. Tous les employés doivent savoir ce que l'on attend d'eux et à qui ils sont responsables. Si l'administrateur finance son temps et

délègue son autorité, il aura le temps voulu pour étudier les nouvelles promotions, surveiller la coordination des départements et occasionnellement accorder aux détails administratifs une attention particulière. En d'autres termes, il aura le temps de fair fonctionner les rouages divers de l'administration avec harmonie et rendement. Il ne sera pas affairé ici et là pour mener rien à bien.

On remarque actuellement que l'administrateur tend trop à se confiner aux seuls intérêts de son hôpital. Cette politique d'isolement n'est pas bonne. Il lui faut assister aux congrès, visiter d'autres hôpitaux et causer avec leurs administrateurs. Il doit aussi prendre intérêt aux questions portées à l'attention des organismes provinciaux et du Conseil des Hôpitaux Canadiens.

L'Ambiance

Dans un hôpital, un malade s'apercevra vite de sa qualité; elle vient de toutes les personnes qui prennent part au service hospitalier. Le malade attend de la compétence dans les soins qu'il doit recevoir; mais de plus, il attend de la courtoisie, de la bonté, du bien-être, de la considération et de la patience. Quand il entend des paroles de mécontentement, des critiques sur l'hôpital de la part de ceux qui sont à son service, il en déduit que quelque chose va mal et il retire sa confiance.

Souhaitons la bonne administration qui crée l'harmonie et développe une bonne ambiance, mais n'oublions pas qu'aucun hôpital ne donnera son plein rendement s'il manque d'âme. Il sera possible d'y trouver tous les services, mais cette déficience amoindrira toujours sa valeur.

Hospital Publishes Literary Bulletin

The historical committee of St. Joseph's Hospital at London, Ont., has recently undertaken to publish a bulletin. The editor of "The Bulletin", Dr. J. W. Crane of London, is a former staff member of the University of Western Ontario Medical School and former alumni director for the University, and is well known for his special interest in the preservation of local history. The first volume began a series of biographical sketches of the staff interns.

Payment for Hospital Care

(Concluded from page 39)

recorded, however, that the "point system" provided a means of grading and standardization of hospitals and furnished a financial incentive which resulted in the improvement of the facilities of most of the smaller institutions in Saskatchewan within a short space of time.

During the three years 1948 to 1950 inclusive, the Plan's payments to Saskatchewan general hospitals were made on the basis of inclusive per diem rates intended to cover the estimated cost of efficient operation in individual institutions. In hospitals with 50 or more beds the per diem rate for adults and children dropped 35 cents after the first ten days of stay and another 35 cents after twenty days. In hospitals between 15 and 49 beds the differential was 30 cents and in smaller institutions, 25 cents. All hospitals in these groups were also paid at the rate of $2.00 per patient day for newborns.

Disadvantages

There were some disadvantages inherent in settlement of hospital accounts on the basis of inclusive per diem rates which eventually led the Saskatchewan Hospital Services Plan to adopt the present system of payment. In the first place, inpatient revenue of hospitals fluctuated in almost direct proportion to the level of occupancy, thus creating some difficulty in financing relatively fixed expenses during certain periods of the year. Secondly, the financial incentives of the inclusive per diem rate system of payment were in contradiction to hospital standards. In other words, the financial incentives encouraged overcrowding in hospitals because lowered occupancy would mean a drop in patient revenue. With a province-wide hospital care insurance scheme in operation, such overcrowding could contribute to pressures for the erection of unnecessary hospital facilities.

In addition to facilitating the matching of monthly hospital revenues against expenditures, the Plan's present system of payment also seems to have reversed the financial incentives of hospital managements in regard to the question of occupancy. This is the result of the fact that lump sum payments in most cases will represent slightly more than fixed expenses and per diem payments slightly less than variable expenses, thus causing a financial loss if occupancy exceeds the estimate or a surplus if occupancy drops below the estimate.

Individual Responsibility

Man-study with its corollary man-building, has become the leading necessity of modern industrial life. It matters not how great and successful a modern business may be, how vast its assets, how unquestioned the value of its public services and the sum of its good will, the final measure of its strength may be stated in the simplest terms, the collective strength of the individuals who are responsible for its destinies. This applies not only to the high executives, but to all employees, for each one, be his task relatively great or little, is charged with his own measure of responsibility for the final result.—*Mooney and Riley in "Principles of Organization".*

Life Insurance Companies Award Research Grants for Heart Disease

Heart disease research will receive grants totalling more than $725,000 this year from the life insurance companies of the United States and Canada, it has been announced by the president of the Life Insurance Medical Research Fund. The 1951 awards bring to nearly four million dollars the amount of money given to heart disease research by the life insurance companies since the Fund was organized in 1945.

Included in this year's grants are 51 research awards amounting to $597,450 and 36 research fellowships totalling $129,500. Since the first grants of the Fund were made at the beginning of 1946, a total of 166 research programs and 165 research fellowships have been supported. This year three Canadian universities will benefit by the research grants: Faculty of Medicine, McGill University, Montreal, P.Q.; Faculty of Medicine, University of Western Ontario, London, Ont.; and the School of Medical Sciences, University of Saskatchewan, Saskatoon, Sask.

Coming Conventions

Apr. 16-18—Annual Conference of Blue Cross and Blue Shield Plans, Buena Vista Hotel, Biloxi, Miss.

May 3-4—A.H.A. Institute on Laundries, Palmer Hotel, Chicago, Ill.

May 7 (week)—Second Ontario Institute, Queen's University, Kingston.

May 9-11—Sectional Meeting of the American College of Surgeons, Book-Cadillac Hotel, Detroit, Mich.

May 28-30—Biennial Meeting of the Canadian Hospital Council, Ottawa.

June 2-5—Catholic Hospital Association of United States and Canada, Convention Hall, Philadelphia, Penn.

June 4—Maritime Hospital Association, Algonquin Hotel, St. Andrews-by-the-Sea, N.B.

June 18-22—Canadian Medical Association, Mount Royal Hotel, Montreal.

June 18 (week)—Western Canada Institute for Administrators and Trustees, University of Alberta, Edmonton.

June 25-27—Congrès des Hôpitaux Catholique du Québec.

July 15-21—Second Postwar Congress of the International Hospital Federation, Brussels, Belgium.

Sept. 12-15—Canadian Society of Radiological Technicians, Royal Alexandra Hotel, Winnipeg.

Sept. 17-20—American Hospital Association, St. Louis, Mo.

Oct. 11-12—Saskatchewan Hospital Association, Hotel Saskatchewan, Regina.

Oct. 16-19—British Columbia Hospitals' Association, Hotel Vancouver, Vancouver.

Oct. 22-26—A.H.A. Institute on Hospital Purchasing, Moraine Hotel, Highland Park, Illinois.

Oct. 24-26—Associated Hospitals of Manitoba, Winnipeg.

Oct. 29-31—Ontario Hospital Association, Royal York Hotel, Toronto.

Nov. 20-24—Maritime Hospital Association Institute for Hospital Trustees and Administrators, Halifax, N.S.

Nov. 26-30—A.H.A. Institute on Hospital Laundry Management, Kenmore Hotel, Boston, Mass.

ISWC to Hold World Congress in Stockholm, Sweden

The International Society for the Welfare of Cripples will hold its fifth World Congress in Stockholm, Sweden, from September 10-14, 1951. All persons interested in and working for the care of cripples are invited to attend. Questions regarding preventive medical treatment and social and pedagogic care will be included on the program. Discussions will be held on such topics as the prevention of invalidity, co-operation between medical and social care, education of crippled children, vocational guidance and training, and the disabled and the labour market. Sectional meetings will be arranged for different categories of workers and study-tours to social institutions will also be conducted.

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New Burroughs' typewriter bookkeeping machine, Style 780878, for compiling payrolls, inventories, recording accounts receivable, accounts payable. This machine has never been in use. Apply Box 832B, Canadian Hospital, 57 Bloor St. West, Toronto.

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Hospital Storekeeper (middle-aged) 6 years in present position, desires change. Thorough knowledge of stock control, and receiving and issuing of surgical and general supplies. Highest References. Could arrange to be free within a reasonable period. Apply Box No. 163G, Canadian Hospital, 57 Bloor St. West, Toronto 5, Ont.

DIRECTOR OF NURSES

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LABORATORY TECHNICIAN WANTED

General Hospital, 185 beds. For information apply to Superintendent of Nurses, Medicine Hat General Hospital, Medicine Hat, Alberta.

WANTED — NIGHT SUPERVISOR

Apply stating salary expected, age, religion and qualifications to Superintendent, Cottage Hospital, Pembroke, Ont.

WANTED IMMEDIATELY

Dietitian for 185 bed hospital and School of Nursing. Salary $175 per month plus board, room and laundry. For full particulars apply Superintendent of Nurses, Medicine Hat General Hospital, Medicine Hat, Alberta.

ASSISTANT SUPERINTENDENT SEEKS POSITION

Assistant Superintendent of a large hospital desires a position as Hospital Administrator or post of Assistant Administrator in a large Institution. Four years experience in methods and procedures of administration. Four years as Officer in Canadian Army in charge of supplies for General Hospitals and Field Ambulances. Apply to Box 325D, The Canadian Hospital, 57 Bloor St. West, Toronto 5.

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APRIL, 1951

(For Subscription Rates See Page 98)

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